Virginia Medical Monthly

Vol. 80, No. 6
WHOLE No. 1212

RICHMOND, VA., JUNE, 1953

$2.00 A YEAR
25 CENTS A COPY

GUEST EDITORIAL

The Modern Trend of Medical Thought

AS THE extensiveness and thoroughness of subversive forces in America unfolds before our astonished gaze, it seems unlikely that any phase of our national life is exempt from its attack or immune from its effects.

We have found evidences of it in our educational structure from the early grades through graduate school. Our economic structure, especially organized labor, is a ready medium for it. Literature is rife with radical and communistic ideas, especially where it can act most effectively, as in movie script. Pornography and filthy literature seem to thrive in this atmosphere of total irresponsibility.

The moral structure of America has thus been honey-combed with physically attractive ideas such as atheism; free love; rationalism of honesty, to teach that all is good "if one can get away with it". It is of little wonder that the American home has been endangered, divorce commonplace, dishonesty current and immorality rampant.

Certainly, most of us were surprised to find communism deeply entrenched in the high government places. Some of us have been naive enough to disbelieve the evidence that Hisses, Fuchs, Goldsteins and Rosenbergs, to mention only a few, could betray this good, free life of theirs, in this great land of ours.

This has been no sudden change, but its rapidity of growth has been phenomenal. First the physical rather than ethical ideas must gain prominence in our thoughts. The exaggerated importance of luxury, ease and comfort soon exalts the dollar which is its medium of attainment. With these altered ideals it is but a short step to cynicism, fear and selfishness. All of this in the name of progress adds to its danger.

In view of this widespread infiltration of our whole national life by unhealthy psychology, it seems highly improbable that our great medical profession should be exempted. It would seem timely to look for symptoms and signs of the inroads on our present medical thought by materialistic and therefore subversive ideas.

Are we older men forgetting the Hippocratic Code, so deeply impressed upon us by our preceptors? Are we thinking more of our fatigue and physical comfort than the cure of illness about us? Are our younger colleagues being taught that this great profession is primarily for service to others? That respect in public opinion, and the satisfaction of leading a useful, fruitful life for our fellow man is more important than money? When our medical schools choose their candidates, are their spiritual backgrounds considered as much as class grades? If not, the profession must lose the confidence of our public, certainly one of its greatest assets.

Should we expect pay for our every effort in behalf of people? In fact, should we expect full payment for any effort? A few weeks ago a prominent man and his wife were in a terribly disabling automobile wreck. In a short while a physician's car came by and he gave aid, until an ambulance arrived to take the victims to a nearby hospital.

The feeling of gratitude was great in the patient's heart for the help given by the physician and he wished he knew his benefactor's name so that he could at least write him a note of thanks. In about two or three weeks a bill was received for $35.00 for each victim. The statement was itemized, "charge for extricating from accident".

XUM

The patient knows of no unusual first aid being rendered or dressing applied. A great plug for our public relations had been passed up. Materialistic selfishness replaced the urge to help the unfortunate sick. On the surface, certainly, this type of thing lowers our profession to the level of the trades.

Our public relations demands that we resurvey our destination in medical thought today. It demands that we go the "extra mile" and give some service for the sheer delight of being helpful to our fellow man. This is an art and service which must be given cheerfully and in excess of material return. "Man cannot live by bread alone", nor can the medical profession by monetary gain.

H. GRANT PRESTON, M.D.
Harrisonburg, Virginia.

IS SOCIALIZED MEDICINE DEAD? Leave it to Representative Dingell (D., Mich.) to keep the socialized medicine issue alive, even with the change to a Republican administration in Washington.

Like the perennial plant that blooms each year, Mr. Dingell introduced compulsory national health insurance legislation as soon as the new Congress opened for business. At the same time he issued a statement, saying that his bill had the same objectives as the report of the Truman Commission for the Health Needs of the Nation and the "same freedom from socialistic taint."

"It is my aim," he said, "to keep this legislation before Congress."

$10,000,000 is needed to augment the national fund for our medical schools during 1953. A goal of $2,000,000 has been set by the American Medical Education Foundation as its contribution to this requirement. Your contribution will assist your medical school and it is a deductible item when computing federal income taxes.

OSLER AND WELCH
FOUNDERS OF MODERN AMERICAN PUBLIC HEALTH*

HUNTINGTON WILLIAMS, M.D.,
Commissioner of Health of Baltimore City,
Baltimore, Maryland.

Dr. William Osler, later Sir William Osler the Regius Professor of Medicine at Oxford University, was born at the edge of the wilderness just a bit to the north of Toronto on July 12, 1849. From the Toronto Medical School he passed to McGill University in Montreal, then to the University of Pennsylvania and he came to Baltimore with the opening of the Johns Hopkins Hospital on May 7, 1889. Here he stayed until his departure for England on May 19, 1905.

Dr. William H. Welch was born in Norfolk, Connecticut, almost exactly nine months after the birth of Osler, on April 8, 1850. From Yale he went to the Bellevue Hospital Medical College in New York City and came to Baltimore in October, 1885, at the age of thirty-five years, almost four years before Osler was to come; in reality, Welch was the foundation stone on which the Johns Hopkins Hospital and the Johns Hopkins Medical School were built. He stayed in Baltimore until his dying day, April 30, 1934, and during his long and distinguished career become the Dean of American Medicine.

Together Osler and Welch revolutionized medical education.

Together they reached the topmost heights in their chosen profession and as civic leaders, and

Together they fought the battles that have put American Public Health where it is today.

Of course, many, many other teammates made their successes possible, but they were everywhere recognized as the leaders in what Simon Flexner would call the Heroic Age in Modern Medicine.

It was the purest chance that Dr. Welch's sister married a close cousin of my Father, who had come to the Johns Hopkins University in 1883 when the institution was only seven years old and where he became the first professor of geology; so it was the very best of fortune for me to grow up under the strong influence of Osler and Welch and Dr. Henry M. Hurd, the first superintendent of the Johns Hopkins Hospital in Osler's day, whom I knew as Uncle Henry, for he had married my grandmother's sister.

Osler left Baltimore when I was a bit over twelve years old, but I can clearly remember being sent to his office by my Mother for a routine physical examination, and even more clearly as a member of a faculty family, listening to him deliver his going-away address, *The Fixed Period.* This, you will remember, was his famous and much misinterpreted speech in which he was seeking to lessen the note of sadness due to his approaching separation from old friends and in which he facetiously commented on the peaceful departure of men at the age of sixty by chloroform. He was the principal speaker at the annual exercises commemorating the opening of the Johns Hopkins University which then in 1905 as now are held by tradition on Washington's birthday.

Again, it was most fortunate indeed for me to be of the vintage of a senior medical student in October, 1918, when the newly established Johns Hopkins School of Hygiene and Public Health first opened its doors and I was on the doorstep to enter as a first student. As you know, there had never before been a specially constituted academic institution established for the sole purpose of training health officers and other health department professional workers. This new and pioneer achievement of Dr. Welch's just prior to his seventieth birthday was characteristic of the man, for he went from one magnificent achievement in medicine to another through his long life at seemly and appropriate decennial intervals.

So, what more natural than for my Cushing's *Life of Osler* and my copy of the Flexners' *William H. Welch* to be pock-marked in the margins with P.H., P.H., P.H., or for me long ago to hope for an occasion to put together the story of these two great men and their major contributions to modern American public health?

WILLIAM OSLER

Anyone who remembers or has read of either Osler or Welch will recollect the deeply religious background that was woven into the early childhood of

*Read before the Annual Meeting of the Section on the History of Medicine of the Richmond Academy of Medicine, Richmond, Virginia, February 10, 1953.

XUM

each of them. This probably was the basis for their seriousness of life-purpose and the explanation of their abiding success. Both alike were endowed with very rare humor and a *penchant* for practical jokes that surely endeared them to the onlookers, if not always to the victims of these practices.

So at the early age of fourteen, Osler was expelled from school for practical jokes that did not appeal to the school authorities, and from this early day throughout his life he was known for his puckishness. But I must get on to my theme which is his interest and achievements in public health.

He writes that when he began clinical work at the Montreal General Hospital in 1870, the hospital building "was an old coccus- and rat-ridden building . . . pneumonia, phthisis, sepsis and dysentery were rife." Tuberculosis and its control were to be among Osler's greatest interests throughout his life. Two years later he received a special graduation prize for his thesis, which, though never published, remains to us in its fragment, the introduction, in which he wrote:

"To investigate the causes of death, to examine carefully the condition of organs, after such changes have gone on in them as to render existence impossible and to *apply* such Knowledge to the *prevention* and treatment of disease, is one of the highest objects of the Physician. . . ."

This early emphasis and interest on studying the etiology of the killing diseases coupled with the desire to apply knowledge for the prevention as well as for the treatment of disease is striking to the health officer disciple. We must remember that both Osler and Welch in those days lived in the midst of great surges of killing communicable diseases such as we rarely see nowadays, and lost friends and loved ones and colleagues in a way that would terrify us today. So, it was more than natural that our two medical heroes were constantly being stimulated to give sharp personal attention to improving the public health in their day.

Following his medical graduation in 1872, Osler writes of the sanitary reforms instituted in Berlin by Virchow. We see Virchow, the pathologist, fifty-two years of age, and Osler, twenty-four years old, and get this picture of Virchow, the leading medico active in public works and public health, described by Osler as

". . . an ardent politician, evidently the leader of the Prussian Opposition, and a member on whom a large share of the work of the budget falls; an active citizen, member of the Council, and the moving spirit in the new canalization or sewerage system . . ."

Back in Montreal, we find the record of Osler working in the smallpox wards, with this killing disease particularly prevalent and malignant in the city in 1875, as frequently seen in most seaport towns at that time. There was no compulsory vaccination, rarely any revaccination and nothing much in the way of quarantine. An antivaccination riot occurred in the city, during which it is recorded that the house of one of the medical health officers was gutted. And in the autumn of the year, although repeatedly vaccinated and considered immune, Osler comes down with smallpox himself.

Osler studied trichinosis in Montreal and reported to the city board of health with emphasis on the need for a municipal food control service. This is early evidence of what became a life-long habit with both Osler and Welch, namely, to play a large part in the modernizing of the local public health machinery, decade by decade, in whatever city either might be residing at a given time.

We are now in the year 1882 when Koch announced the discovery of the tubercle bacillus in his celebrated address in Berlin on March 24. By July there is in a local Montreal medical journal a note to the effect that at the McGill Physiological Laboratory, Professor Osler, before the class of senior students, successfully demonstrated the presence of the organism in the lung of a man who had died of rapid general tuberculosis.

We can skip to Osler's arrival in Baltimore in 1889. Welch is there and the two are soon joined by Dr. Hurd, Superintendent of the new Johns Hopkins Hospital, chosen to relieve the president of the university, Daniel C. Gilman, from his own self-imposed task of serving from May to August as hospital superintendent.

Osler gave the larger part of 1891 to the writing of his great textbook, *The Principles and Practice of Medicine*. On February 22 of that year he gave the main address at the Johns Hopkins University annual ceremonies, and as local public officials were present with the University on the occasion, Osler felt impelled to think of the notoriously unsanitary conditions which then existed in Baltimore and spoke with emphasis on the prevention of disease through sanitary science, and told of the possibilities of intelligent cooperation on the part of the city govern-

XUM

ment that would result in better sewer facilities and purified water supplies that could reduce "the mortality from certain diseases fifty per cent."

At the annual meeting of the Medical and Chirurgical Faculty, our state medical society, in April of that year, Osler gave an address under the title, *The Healing of Tuberculosis,* which Cushing states "may be regarded as the date of his personal enlistment in the crusade against this disease—a crusade which demanded, above all else, the awakening of public opinion from its existing indifference and ignorance . . . his vigorous early participation in what has become a world-wide campaign against tuberculosis must stand in the forefront of the many public services he rendered—services which in large measure have been lost sight of in the maze of his other activities."

Again he returns to the battle against typhoid, a disease regarded in the early 90's with civic indifference although the same disease which today is looked upon as a disgrace in any community. It was in large measure Osler who brought about this change in attitude and in his paper on "Typhoid Fever in Baltimore" in 1894 he enlists in this battle for improved public sanitation and writes:

"Among the cities which still pay an unnecessary Delian tribute of young lives to the Minotaur of infectious diseases, Baltimore holds a high rank. The pity of it is, too, that this annual sacrifice of thousands of lives (2,281 for 1892, not including consumption), is not due to ignorance. For more than fifty years this gospel of preventive medicine has been preached—whether they would hear or whether they would forbear—in the ears of councils and corporations; that *three measures, efficiently designed and efficiently carried out, reduce to a minimum the incidence of infectious diseases: viz, pure water, good drainage, and a proper isolation of the sick.* Of sanitary essentials in a modern town, Baltimore has a well-arranged water supply; still, however, with unprotected sources and constant liability to contamination. It has nothing else—no sewage system, no system of isolation of the sick, no hospital for infectious diseases, no compulsory notification of such a disease as typhoid fever, no disinfecting station, no system of street-watering, no inspection of dairies, no inspection of meat. The streets are cleaned, but so carelessly that for a large part of the year the citizens breathe a mixture of horse-dung and filth of all sorts. Perhaps the best gauge of the sanitary conditions of a city is to be found in the mortality returns from typhoid fever."

Cushing, in a footnote, here returns to his earlier theme and writes:

"The influence which, first and last, Osler exercised as a national and civic sanitary propagandist has been too little emphasized. To-day in our comparative security against serious epidemics it is difficult to realize the annual death-roll of the '90's from diseases now under control."

And I would add here that my own Father died of typhoid in 1894 and Osler went to see him in Utica, New York, toward the end.

As hinted above, Osler was stimulated in this reform effort because one of his assistant residents in the hospital was ill with the typhoid which proved fatal, and this staff member was not the only victim of typhoid among the hospital family. "Typhoid in the United States," he wrote, "is *the fever.* With good drainage, pure water and pure milk, typhoid fever goes the way of typhus and cholera . . ." and he showed that the mortality rates of Washington and Baltimore and many smaller cities demonstrated the culpable negligence that allowed this most easily preventable disease to continue its ravages.

Osler became President of the Medical and Chirurgical Faculty in 1896. He aroused the venerable society from its lethargy and among other things forced it to take a definite stand on issues relating to the public health. A Health Department bacteriologist had been appointed by the Baltimore City Health Department but the body as a whole was still dormant and badly needed the awakening which could only come from an enlightened public opinion. Osler spoke on these matters—a reorganized board of health, remodeling of the lunacy laws, proper milk inspection, proper control of water supplies, and a hospital for infectious diseases.

Osler and Welch started battling against the antivivisection legislation in Congress in 1896 and 1897 and with great acumen continued watching over this vital matter as the years went by, returning to the fray in 1900. It is only someone who has gone to the legislative halls on repeated occasions to battle some recurring bad medical bill who can appreciate what this meant to medicine in the United States, this willingness on the part of both Osler and Welch to pull themselves away from their regular work and interest, and fight the public battle for medicine and the public health.

XUM

Just as the century closed in November, 1899, Osler at the Medical and Chirurgical Faculty annual meeting takes up the cudgels again that he was so long to wield in an effort to conquer tuberculosis, and the paper he read at the meeting on "The Home Treatment of Consumption" is an important one. He has a nephew who, with one or two Johns Hopkins students, are cured under the supervision of Trudeau in the Adirondacks, but the story was different for the poor people in Baltimore who came traipsing to the hospital dispensary from terrific home and housing conditions that made the disease a prime killer in our city.

Yet it was the closeness of tuberculosis in Osler's nephew and in such students as Lawrason Brown and others that must have been a tremendous stimulus to Osler who concerned himself on a broad base with the health of the medical students and with tuberculosis in particular. Here is a dramatic episode: Osler called for volunteers and sent two third year medical students out to visit, investigate and instruct in the homes of consumptive outpatients, a work which grew and grew and was the basis on which all hospital social service work in this country was founded. One of the students gave a report on the social and domestic conditions of 190 cases of pulmonary tuberculosis that had been followed up in this way, at the first meeting of the Laennec Society. Welch was present and participated in this interest and in this work, and we can almost see the daily interplay between Osler and Welch during their years at Johns Hopkins together, in their absorbing public health interests as well as in other fields of medical science and medical education.

The health of the medical students, many of whom lived in unsanitary boarding houses, was a constant worry. A third year boy, worn out by his June examinations, is admitted to the hospital with tuberculosis, and Osler and Thayer are practically held responsible for this by the boy's family. In the single class of 1899, four students develop tuberculosis and J. B. MacCallum, said to be perhaps the most brilliant student ever graduated from the school, was beginning with the disease which ended a career of unusual promise four years later.

We are now in the year 1902. Dr. Welch is the President of the Maryland State Board of Health and Dr. Osler suggests a public meeting on the need for municipal tuberculosis sanatoria. The meeting was held under joint auspices with the Medical and Chirurgical Faculty of Maryland and the Laennec Society and other groups, and, as Cushing remarks, Dr. John S. Fulton, Executive Secretary of the State Board of Health, vividly laid bare the ignorance, vice and greed which propagate tuberculosis. This is the famous meeting when, to the amazement of Baltimore, Osler publicly shook his finger in the Mayor's face and told the audience and the Mayor of the 10,000 consumptives and asked what was being done about them. "We are doing, Mr. Mayor and fellow-citizens, not one solitary thing that a modern civilized community should do," and he told them of the two medical students who had visited the cases in their homes during the past few years and how the reports of these home visits constituted a community disgrace.

A physician who was present said that this unlooked for tirade made his hair stand on end and rather looked for a southern duel, but to his surprise later in the evening he saw the Mayor with his arm over Osler's shoulder and the conversation was of a most affectionate nature.

Here we have a striking example of Osler that can be matched in a way with Welch. Osler's speech was fiery and on purpose but he had always sympathy for others, and in this case for the man whose civic apathy he was exposing, a good hard-working fellow who didn't get his deserts. All this was done in such a way that they go out from the meeting arm in arm and affectionately. What a gift! Multiply this over the sixteen years and you will not wonder why public health workers and medical men in Baltimore cherish the memory of Osler, as it is cherished everywhere.

Watch Dr. Welch and a gentler but none the less persistent and effective approach. It was at about the turn of the century and Welch had taken advantage of a cholera scare to drive home to the public particular needs in health reforms after two generations of citizens' committees and health officials had been pleading for the purification of the city water supply. But Flexner tells us that Welch believed that

"under our existing political conditions, experience seems to show that more can be accomplished by the quiet, intelligent and well-directed efforts of individuals and of such organizations as societies for city improvement, which do not directly antagonize those who wield political power, and which receive the approval of the general public, than by spasmodic political movements for reform," and on the matter

XUM

of giving advice the biography adds that Welch "criticized only indirectly through suggesting something better."

Here by way of contrast you see two master scientific minds, integral parts of great human personalities, of what you might call the "gentle-fighting" type, each giving primary attention in his own way to accomplishing the removal of the lion-in-the-path obstacle that simply must in time be removed, the practical solution that would lead to achievement for the good of the people, for the prevention of disease, and for the protection of community health; each giving the problem the same meticulous personal attention and concern that a master surgeon would give in devising the infinite details that might result in a successful brain operation.

It is not to be wondered that over the years the governors of Maryland and the mayors of Baltimore have gone to such medical leaders as Osler and Welch, and, in our day, Maurice Pincoffs, and, indeed, to the Medical and Chirurgical Faculty almost as a habit, for quiet, behind-the-scenes guidance and advice when important decisions on medical matters cried out for statesman-like answers from our top government executives. I need only mention two fairly recent and striking examples of this, the discontinuance of the coroner system and its replacement in Maryland by the medical examiner system and even more important the adequate financial support of the new system when established; and the establishment under the State Planning Commission of a standing Committee on Medical Care with a resulting Medical Care Program now in operation through the state for a number of years and designed as Maryland's preventive answer to those who cry insistently for socialized medicine and compulsory health insurance.

Then there is the episode of the great Maryland State Tuberculosis Exhibit of 1904, followed by the organization in Atlantic City in June that year, of what is now the National Tuberculosis Association, and with Osler in the chair. And during the same year Harvard University would like to persuade Osler to move from Baltimore to Boston, but the call comes for him to become Regius Professor of Medicine at Oxford, a call he simply could not decline.

Cushing's second volume takes Dr. Osler from a noisy, hurly-burly Baltimore to the quiet of an Oxford suburb and follows him in magnificent detail from 1905 to the end of the story and his death on December 29, 1919. With great fascination the reader can follow Osler's joy in being at the heart of British medicine, with all the academic and cultural delights that went to his heart, his insistent collecting of rare medical volumes, and the writing of biobibliographies, each a scintillating chapter in medical history.

As in America, tuberculosis was a prime interest of Dr. Osler and he followed the same driving tactics in Ireland and in Britain in a combat with the tubercle bacillus which he called a people's battle. The antivivisection cause is fought again on a new battleground and the malaria control work in Rome is an interest and an activity in 1909. He revisits America from time to time. In 1909 it was for the dedication of Osler Hall, the big lecture hall and examination room that many of us know so well in the new Medical and Chirurgical Faculty building at 1211 Cathedral Street, I might add "the street where I was born." In 1913 it was for the opening of the Phipps psychiatric building at the Johns Hopkins Hospital, the last time that I saw him.

In 1910 Osler is at work fighting tuberculosis again and I may be permitted a few lines directly from Cushing:

"One cannot escape the feeling that Osler's greatest professional service was that of a propagandist of public health measures. His beginnings in this direction, seen even in his youthful days in Montreal, were actively continued in Baltimore, where he was constantly crusading against malaria and typhoid, not only in his wards but on public platforms; and he left there just as the anti-tuberculosis crusade was getting under way. With this same movement, as can be seen, he energetically allied himself while in England; nor was his a voice in the wilderness in this role he chose for himself—a role as important as that of the laboratory scientist whose cloistered studies supplied the knowledge on which our whole public health movement is based."

And so it was with Osler's interest in tropical diseases and their prevention, Osler acting on a world-wide stage as was frequently his custom; and Osler battling for compulsory typhoid vaccination among the troops in World War I, before the end of August, 1914. "In war the microbe kills more than the bullet," he writes. His one and only child, Revere Osler, goes off to the war, and what parent who ever had a soldier son at the front can read these pages of Cushing without emotion. And the

XUM

dreaded day comes when the boy is reported wounded and then dies at the end of August, 1917, and he is buried in a field in Flanders, a picture recalled as "A strange scene—the great-great-grandson of Paul Revere under a British flag, and awaiting him a group of some six or eight American Army medical officers—saddened with thoughts of his father."

The end of the war and the great influenza pandemic found Osler at the age of sixty-nine; there are rumors of his ill-health which he disclaims. With demobilization Osler and other leaders prevail upon *The Times,* after applying considerable pressure, to discuss the danger to the public health from the possible spread of venereal disease and this probably was his last campaign. In this final year *The Times* refers to him as one who "has done more than any man of his time to secure a true perspective in health affairs."

WILLIAM HENRY WELCH

In telling of Osler's prime activities in the field of public health it has been impossible not to refer to Dr. Welch from time to time—they were such intimate colleagues. Welch like Osler spent about two years in Europe, chiefly in Germany, in postgraduate work in the best of the medical laboratories, 1876 to 1878. In Munich he worked in the famous hygienic laboratory of Max von Pettenkofer and learned there that the sanitary reform of water purification would almost abolish typhoid fever, and in Berlin he enrolled in the first public course in bacteriology ever given by Robert Koch, the founder of the science, in his new laboratory there.

Returning from Europe, Welch spent six years in New York intent on establishing laboratory courses rather than lecture courses, in a time when laboratories were practically unknown in American medical schools. At the Bellevue Hospital Medical College he was given three rooms furnished with kitchen tables and the college, as he said, spent "fully twenty-five dollars in equipping the laboratory. . . . I sometimes feel rather blue when I look ahead and see that I am not going to be able to realize my aspirations in life. . . . There is no opportunity in this country, and it seems improbable that there ever will be," he wrote. Welch collected six antique microscopes and six students to work in pathology; the first laboratory course in pathology ever given in an American medical school. One of his students was Dr. Hermann M. Biggs and the fascination of Welch's pioneer course in bacteriology so captivated Biggs that he dedicated his life to the science and later became the greatest public health administrator America has ever known. With Koch's discovery of the tubercle bacillus and Welch's demonstration of the organism in his laboratory class which included Biggs, there is this description of Welch, the teacher, by Biggs, the student:

"In his most lucid and fascinating manner, he told us of this great work and of its significance to the future development of medicine. He showed us methods of staining sputum and demonstrating the tubercle bacilli. I can now see quite clearly the steam rising from the dish of carbol-fuchsin in the sand-bath containing the sputum while he talked. This served as my first inspiration."

His New York friends were distressed when Welch indicated that he might accept the invitation of President Gilman to come to the Johns Hopkins Medical School, but Gilman had the strongest recommendations from the professors in Germany and when the invitation finally came, Welch accepted it at the end of twenty days. It was during the period when he was considering this offer of the chair of pathology at Johns Hopkins that he received a letter from my Father, then at work in geology in Baltimore after three years in Heidelberg. Welch said that Father presented the matter of his coming to Johns Hopkins in about the same light in which he saw it. Father wrote that "no place in America offers the real opportunity for true scientific work which this does. You have said the same thing to me yourself." Furthermore, as a full professor Welch would have, like other full professors at Johns Hopkins, "literally perfect independence and everything for your work that you ask for." Welch would be able to organize the Medical Department from the very beginning and to build his library exactly as he wished, thus becoming the founder of a new medical school. "It seems to me," my Father continued, "that it is an opportunity for giving a start and impetus to the spirit of real scientific work which is thus far so sadly lacking on this side of the Atlantic, which can come to a man only once in a lifetime."

And Flexner writes:

"At thirty-five Welch had found himself a place in the world that was perfect to his needs and desires. For many years a genie confined in a bottle, he rose up, once the cork was pulled, into his true dimensions, and for almost fifty years he was to tower

XUM

over American medicine, determining, creating, helping change a backward profession into a leading profession of his time. Moving in a highly controversial field toward revolutionary ends, he was always gentle, never raising his voice above the tone of ordinary talk. He won campaign after campaign but never fought a battle; haste was unknown to him, or anger or the exuberant joy of putting an opponent down. He was to win affection and admiration until he became, first to his associates and then to younger scientists everywhere, in common parlance the beloved 'Popsy.' "

Although the Johns Hopkins Hospital was not to open until May, 1889, and the Medical School was not to open until October, 1893, Welch began instruction in general pathology and the pathology of fever and gave a course in bacteriology beginning in October, 1886. Of the latter course he said at the time, "So far as I know no similar course is given in this country and only three or four in Europe." At the end of this first academic year Welch reported jubilantly that twenty-six medical graduates had made use of his laboratory and that eight had undertaken original investigations.

From the first, as Flexner points out, Welch's life in Baltimore was that of a confirmed bachelor who knew how to make himself comfortable. He moved from Cathedral Street to 935 St. Paul Street (the house from which I was fortunate many years later to take my bride who is with us this evening) and later to 807 St. Paul Street, quite nearby. The Maryland Club and the University Club, both just around the corner, were large parts of Dr. Welch's life and the chosen haunts for the famous dinners that were so often his joy and a basis for some of his most effective achievements. Then, too, he was close to the Surgeon General's Library in Washington. And here is an intimate picture of his front studyroom catching fire in his absence in 1889, a room which, he said, contained a thousand and ninety books not including many unbound ones and pamphlets, with a large number of books and pamphlets in his bedroom that were not injured. This was a true picture of the man over the decades for I saw exactly the same distribution of printed matter when I went to the St. Paul Street rooms early on Welch's eightieth birthday to give him, for my Mother, a choice bottle of Madeira from Mr. Charles J. Bonaparte's cellar.

It is good to have in the record Flexner's clarification of the personal relations involved in the selection of "The Four Doctors" who founded the Johns Hopkins Medical School. Flexner tells us:

"Osler's appointment as professor of medicine is usually credited to Billings, but Welch said later that Billings had been opposed to the Canadian, whom he regarded as predominantly a laboratory man; Billings wished the appointment to go to the English physician Lauder Brunton, since he was more experienced in the practice of medicine. Welch, however, insisted that physiological and pathological laboratories were the best training ground even for a professor of practice. When his support of Osler finally prevailed, he wrote his sister that the new appointee 'is the best man to be found in the country and it is a great acquisition for us to secure him. I know him well and have the highest opinion of him as a scientist and as a man.'

"The authorities first offered the appointment in surgery to Sir William Macewen of Glasgow, who accepted, but, having no faith in anything American, made it a condition that he might bring his whole staff of nurses with him. When this was refused, the way was opened for Halsted, whom Welch had known well in New York. The last of 'the four doctors,' the famous first faculty of the Hopkins Medical School, was Howard Atwood Kelly, appointed associate professor of gynæcology and obstetrics in 1889. He was brought by Osler and thus could also be indirectly credited to Welch."

Toward the middle and end of the 90's, Dr. Welch is responsible for the first bacteriologist, Dr. William Royal Stokes, being appointed to establish and direct the public health laboratories which, for a number of years, served jointly the Baltimore City Health Department and the Maryland State Department of Health, and it was Dr. Stokes who was to die a martyr to science in line of duty autopsying a batch of infected parrots in the epidemic of psittacosis of 1930.

In 1897-98 we find Welch in Washington fighting the antivivisection bills in Congress, side by side with Osler. Welch became a political lobbyist, and particular care was taken to reach the family doctors and personal friends of individual senators. Finally the right side won, the committee fled from its chairman and he withdrew the bill. It was presented again in various forms for a number of years but the antivivisectionists had been fully routed. Yet Welch never under-estimated the seriousness of the

XUM

danger and wrote of this episode. "That was the hottest fight, I think, there has been."

At this time early in 1898, Dr. John S. Fulton, long-time Executive Secretary of the Maryland State Board of Health, persuaded the governor of the state to appoint Dr. Welch as a member of the State Board of Health. He attended his first meeting on February 10. My distinguished predecessor, Dr. C. Hampson Jones, the Commissioner of Health of Baltimore, was present and I mention this because since 1880 the state law has placed the Commissioner of Health of Baltimore City on the State Board of Health as an *ex-officio* member. Two years later Welch was elected President of the Maryland State Board of Health and in this capacity he presided over the meetings for twenty-two years and remained a member of the Board until 1929.

In 1936 Dr. William W. Ford, first professor of bacteriology at the Johns Hopkins School of Hygiene and Public Health and a State Board of Health member for many years, put together for the Board a record of Dr. Welch's public health work, and in this he points out that at the regular monthly meetings of the Board that he attended regularly when he was not out of town, Welch always interpreted the term *health* in the broadest sense to mean comfort and well-being as well as freedom from bodily and mental ills. At the meetings he was slow to make a decision, sought ample information in regard to every question, and liked to discuss matters thoroughly and weigh the pros and cons deliberately. His particular contribution may be said to have been his broad outlook for the health needs of the state, his intuition as to which should and could be met first, and his grasp of the ways and means of initiating and carrying out new projects.

As we have seen in 1904 Welch was side by side with Osler at the first great tuberculosis exhibit which was held in Baltimore City and later at the meetings leading to the establishment that year of the organization now known as the National Tuberculosis Association. Besides tuberculosis, other public health programs involving the control of food and drugs, the improvement of the sanitary engineering work in rural Maryland, and especially the development of maternal and child health activities in the counties of Maryland, were before Dr. Welch for consideration at the meetings of the State Board of Health. In 1914 a crucial bill to establish ten sanitary districts in the state, each under a deputy state health officer, a program that now gives each of Maryland's 23 counties its own health department and full-time health officer, ran into some heavy opposition in the legislature at Annapolis. The old problems of local pride, of the State Health Department getting too rich, too strong and too expensive were in back of the opposition. A committee hearing was set and the State Board of Health members were invited to be present. Dr. Ford describes this dramatic episode and Dr. Welch's relation to it because it was characteristic of the many episodes in the great physician's life:

"Dr. Welch was absent from Baltimore at the time this hearing was granted. He happened to return on a night train which arrived about eight o'clock in the morning on the day of the hearing. He was informed by a member of the Board that the situation in regard to the bill was critical and hurried to Annapolis without breakfast to meet the members of the committee, which had already assembled. Surprised to see Dr. Welch so much concerned about the passage of the bill, the committee adjourned until twelve o'clock to permit Dr. Welch to get breakfast and recuperate a little from his trip. At twelve o'clock, every member of the committee and nearly every member of the Board of Health was in attendance to hear Dr. Welch make a clear, forceful, almost impassioned address in which he pointed out the deplorable sanitary conditions in the rural districts of Maryland, the acute need of supervision in health matters, the determination of the Board of Health not to interfere with local officials but to work hand-in-hand with them, and the preservation of health and saving of life which were certain to follow the enactment of the bill. So convincing was Dr. Welch on this occasion and so powerful were the arguments he presented that the joint committee of the legislature was convinced of the desirability of the legislation and a favorable report was agreed on unanimously. The bill was finally passed by the House and Senate in the closing days of the session. If Dr. Welch had not hurried to Annapolis to appear before the joint committee the Deputy State Health Officer's Bill would certainly not have been passed by the legislature of 1914, and might have never been enacted."

In public health, as in medical education and in scientific medicine, Welch played his part on a national and international stage. He attended the meetings of the American Public Health Association

and organized its Laboratory Section. He fought side by side with Osler against typhoid fever and tuberculosis.

In Ford's record it is clear that Welch was always keenly interested in the public health situation in Baltimore City and lent his constant support for its improvement. He took a leading part in the campaign to rid the city water of its typhoid, and with chlorination begun in 1911 the typhoid that year was cut in half as compared with earlier yearly records, and the filtration plant was started at this time.

Now the milk-borne typhoid became apparent when formerly it had been hidden in the mass of water-borne typhoid, and so, over a number of years, working with the Women's Civic League, Welch drove forward until a modern and adequate city milk ordinance was enacted by the City Council in 1917. I can remember Dr. Welch going to public meetings, of which I attended one at the downtown City Club, made up of business leaders, where Dr. Welch forcefully supported the campaign that led to the enactment of this ordinance; and, as a result, typhoid fever has practically disappeared from our city.

From his earliest days in Baltimore until his last, Welch was in touch with the Baltimore City Health Department. There were difficult times prior to 1909 when there was no communicable disease hospital, and it was he chiefly who brought about the creation of Sydenham Hospital, first in a small way at Bayview to the east of the city, and later in 1924 a modern adequate Sydenham Hospital was built at Lake Montebello beside the city water filtration plant.

Since 1900 there has been no board of health in Baltimore, but through the years Welch befriended and assisted Dr. C. Hampson Jones who was, off and on for a period of thirty-six years, the Commissioner or Acting Commissioner of Health in our city until his death at the age of seventy-three in 1932. During the next two years Welch was a tower of strength and assistance to Dr. Jones' successor and helped him in the organization of a body known as the Consultants to the Baltimore City Health Department, a group of roughly thirteen leading physicians representative of the two medical schools in the city, the State Department of Health, the Johns Hopkins School of Hygiene and Public Health and the Maryland Tuberculosis Association. This body has served as the intermediary between the Commissioner of Health and the Mayor and the Board of Estimates on important occasions when added appropriations were imperative and wise guidance on policies was needed. As Ford says: "When opportunity to do active work in the field of public health presented itself, Dr. Welch accepted it as a duty."

It was only natural that President Herbert Hoover at the national celebration of Welch's eightieth birthday in Washington in 1930 would say "Dr. Welch is our greatest statesman in the field of public health, and his public service to the nation well warrants our appreciation of him."

In spite of the length of my remarks I cannot resist a temptation to close with a tribute written to Dr. Welch by Dr. Harvey Cushing as it appeared in the program for the Washington ceremonies and the volume describing them:

"WILLIAM HENRY WELCH

"To have stepped, in the prime of life, into a position of acknowledged intellectual leadership in the profession of his choice; to have occupied that position, albeit unconsciously, for those forty years which have seen the most rapid strides in medical progress of all time; to have had such influence in the furtherance of the medical sciences in this country as to turn the tide of students seeking opportunities for higher education from the Old World to the New; to have been as ready in countless unrecorded ways to share his time and thought with those who were inconspicuous as with those who sat in high places; to have been no less universally respected for his great learning than beloved for his personal charm and companionability; to have stood knee-deep in honours unsought and to have remained seemingly unaware of them; to have rounded out with distinction two successive university positions and, with enthusiasm undimmed, to be now well launched on a third which he is no less certain to adorn—to have done so much, in so many ways, for so many years, and to have aroused no shadow of envy or enmity on the way, betokens not only unselfishness of purpose but that fineness of character which always has been and always will be an inspiration to mankind."

BIBLIOGRAPHY

OSLER

1. Cushing, Harvey: The Life of Sir William Osler. 2 vols. Oxford, 1925.
2. Bulletin No. IX of the International Association of Medical Museums. Sir William Osler Memorial Number. Montreal, 1926.

XUM

3. Contributions to Medical and Biological Research. Dedicated to Sir William Osler, Bart., M.D., F.R.S. In Honour of His Seventieth Birthday, July 12, 1919. By His Pupils and Co-workers. 2 vols. New York, 1919.

4. Biblioteca Osleriana. A Catalogue of Books Illustrating the History of Medicine and Science. Collected, Arranged, and Annotated by Sir William Osler, Bt. and Bequeathed to McGill University. Oxford, 1929.

5. Parfitt, Charles D., M.D.: Osler's Influence in the War Against Tuberculosis. Canadian Medical Association Journal, October, 1942. pp. 293-304.

WELCH

6. Flexner, Simon, and Flexner, James Thomas: William Henry Welch and the Heroic Age of American Medicine. New York, 1941.

7. Papers and Addresses by William Henry Welch. 3 vols. The Johns Hopkins Press. Baltimore, 1920.

8. Contributions to the Science of Medicine, Dedicated by his Pupils to William Henry Welch, on the Twenty-fifth Anniversary of His Doctorate. The Johns Hopkins Press. Baltimore, 1900.

9. Welch, William Henry, M.D., LL.D.: Public Health in Theory and Practice, An Historical Review. Yale University Press. New Haven, 1925.

10. William Henry Welch at Eighty. A Memorial Record of Celebrations Around the World in His Honor. Milbank Memorial Fund. New York, 1930.

11. Ford, W. W., M.D.: The Public Health Work of Dr. William H. Welch. Prepared for the Maryland State Board of Health. Baltimore, 1936.

12. Winslow, C.-E. A., Dr. P. H.: The Life of Hermann M. Biggs, M.D., D.Sc., LL.D. Philadelphia, 1929.

New Books.

Below are listed some of the newer books at the Tompkins-McCaw Library of the Medical College of Virginia, Richmond. These may be borrowed under usual library rules.

Advances in cancer research. Vol. 1, 1953.
Bach—The metabolism of protein constituents in the mammalian body. 1952.
Bauman—Diagnosis of pancreatic disease. 1949.
Gould—Pathology of the heart. 1953.
Haymaker—The founders of neurology. 1953.
Hurxthal & Musulin—Clinical endocrinology. 2v. 1953.
Lemert—Social pathology. 1951.
Morison—Foetal and neonatal pathology. 1952.
Nutrition symposium series. Nos. 3-6, 1951-1953.
Pappenheimer, ed.—The nature and significance of antibody response. 1953.
Sharpe—Brain surgeon. 1953.
Smith & Wermer, eds.—Modern treatment. 1953.
Strecker—Basic psychiatry. 1952.
Tobias—Essentials of dermatology. 4th ed. 1952.

AMA Survey on Hospital Service in U. S.

For the first time in history, hospital births topped the three million mark. The Council on Medical Education and Hospitals' 32nd presentation of hospital statistics reveals that in 1952 there were 3,170,495 hospital births or one live baby born every 9.9 seconds. The report, which appears in the "Hospital Number" of the Journal of the AMA, May 9, shows a continued increase in the volume of hospital service in the United States.

Highlights of the report: 6,665 hospitals registered—with 18,914,847 admissions, compared with 18,237,118 the previous year. Bed capacity statistics show an increase of 11,627 over 1951. Average length of stay of individual patients in governmental general hospitals is more than twice as long as in nongovernmental general hospitals—16.4 days as compared with 7.5 days.

XUM

DUODENAL DIVERTICULA*

GUY W. HORSLEY, M.D.,
and
GUS J. VLASIS, M.D.,
Department of Surgery, St. Elizabeth's Hospital,
Richmond, Virginia

The purpose of this paper is to present a review of our experiences with duodenal diverticula. This pathological entity presents to the physician a challenge as to which course of treatment to follow once the diagnosis is made. Surgeons at times have been disappointed with the results because of the persistence of the gastrointestinal symptoms following operation. Internists, too, have often found medical treatment to be inadequate.

The duodenum is subject to the same factors which predispose to the production of diverticula elsewhere in the digestive tract, and also has special problems of its own because of its anatomy, such as the intimate relationship with the common and pancreatic duct and head of the pancreas. It would appear that the sudden propulsion of the gastric contents against the duodenal wall, the increase in intraluminal pressure caused by the closure of the pylorus, the narrowing at the angulation, and the fact that the third portion is the narrowest would have a bearing on the fact that the majority of the diverticula occur in the second, or descending portion of the duodenum.

In reviewing the cases of duodenal diverticula at St. Elizabeth's Hospital during the past ten years, it was noted that, of a total of 43 cases, only 12 revealed no other associated pathology. The greater number of diverticula occurred on the concave side of the descending portion of the duodenum, the majority being false diverticula. The incidence of diverticula occurring in each portion of the duodenum is as follows: in the ascending portion, 12 cases; in the descending portion, 20; in the transverse portion, 3; in the terminal portion, 1; between the ascending and descending portions, 3; between the descending and transverse portions, 1; and between the transverse and terminal portions, 3. The distribution between males and females was approximately equal, with 23 occurrences in the male, and 20 in the female. Of the 12 with no other associated pathology, six were males and six were females, five were operated upon with excision of the diverticula and subsequent improvement. The remaining cases were treated medically since the severity of their symptoms did not warrant surgery, or the patients were not suitable candidates for surgery because of the psychosomatic factor in their make-up. The remaining 31 had associated duodenal ulcer, cholecystitis; cholelithiasis, diverticula of the colon, and/or other pathology of the gastrointestinal tract. In one of these cases with duodenal diverticula and duodenal ulcer, the diagnosis of the diverticulum was felt to be the major, and not the incidental finding and the patient was operated upon with excision of the diverticula and vagotomy. There was subsequent relief of symptomatology.

The question which arises in the mind of the attending physician after careful evaluation of the symptoms is whether the patient should be placed under medical or surgical treatment. However, the question should be: is surgery justifiable because of the severity of the patient's symptoms.

Perforation of a diverticulum may occur in the course of conservative treatment, but, according to Byerly, this is a rare complication since only six authentic cases of perforation of a duodenal diverticulum have been reported in the American and British literature through March, 1949. We can thus be assured that the medical treatment, even with poor results would be less discouraging than subjecting the patient to an operative procedure which might not give the patient relief from his symptoms. In spite of the fact that perforation of the diverticulum is rare, clinicians should be cognizant of this possibility and the surgeon should not overlook this diagnosis in the face of peritonitis of an undetermined origin.

In order that the discussion of this condition may be more complete, a review of the anatomy of the duodenum is given so that the weak areas of the duodenum which tend to result in diverticula will be noted. In addition, this will demonstrate the best surgical approach for mobilizing the duodenum and locating the diverticula.

The caliber of the duodenum is greater than that of the jejunum, but is not uniform throughout. The duodenum may be divided into four main portions for purposes of identification. The first, or ascend-

*Read before The Richmond Academy of Medicine, January, 1951.

XUM

ing portion is approximately 5 cms. long and is completely movable, more so than any other portion of the duodenum. It passes upward and backward from the pyloric end of the stomach and narrows at the superior angle. It is completely surrounded with peritoneum. As it turns to the right again, the surrounding peritoneum forms the free border of the gastrohepatic omentum. The second, or descending portion, is about 7 cms. in length and extends from the neck of the gall bladder to the level of the third lumbar vertebra. At this level there is a distinct angle similar to that at the superior angle (Fig. 1).

Fig. 1. Wax cast of the duodenum showing the superior and inferior angles. Redrawn from Kellogg

This portion is concave and is covered with peritoneum and the ascending layer of the transverse mesocolon on its anterior surface except where the transverse colon passes in front of it. In the concavity formed, this portion is adherent to the head of the pancreas by connective tissue and is penetrated by common duct and the pancreatic duct, as well as the superior and inferior pancreaticoduodenal arteries. The common duct follows the concave border and enters the duodenum. The pancreatic duct enters at a right angle a little below the middle of the second portion of the duodenum. The third, or transverse portion, is the largest and narrowest, measuring about 12 cms. in length. It ascends toward the left beneath the superior mesenteric vessels and crosses the middle to the left lumbar vertebra where it contracts to form the isthmus of the duodenum. Here it is compressed between the mesenteric vessels anteriorly and the aorta and vertebral column posteriorly. The fourth, or terminal, portion is about 2.5 cms. long and enters at the level of the upper border of the second lumbar vertebra where it turns forward abruptly to become the duodenojejunal flexure.

The symptoms of a patient suffering from duodenal diverticula run the gamut of gastrointestinal symptoms from vague abdominal discomfort to severe pain. The symptoms most often encountered are those referable either to the biliary tract or are suggestive of a duodenal ulcer, the biliary symptoms being most frequent. The predominant symptom is pain above and to the right of the umbilicus.

The usual history given is that of intermittent attacks of pain related to the taking of food, and the discomfort and/or pain occurring a few hours after eating. The patient may also have headache, nausea, distention, water brash, vomiting, and other symptoms suggestive of biliary dyskinesia. This symptom pattern, referable to the biliary tract, may be explained by the greatest frequency of the diverticulum being in the same segment as the biliary tract, and they cannot always be differentiated. The epigastric pain and discomfort with the prime physical finding of tenderness over the Mayo-Robson point are the most consistent landmarks. Pressure over the diverticulum may cause pain to radiate posteriorly to the back and/or below the costovertebral angle.

Positive diagnosis is made only by the roentgenogram and only when one's suspicions are so confirmed is one justified in making a diagnosis of duodenal diverticulum.

The criteria we use for surgical intervention, once the diagnosis is established, are:

1. Symptoms referable to duodenal diverticula which are persistent and not amenable to conservative therapy (after proper medical evaluation).
2. Retention of barium in a diverticulum for four hours or longer.
3. The presence of diverticula that are 3 cms. in diameter or larger.
4. Bezoars of the diverticulum.

At operation an upper right rectus incision is used to open the abdomen. If the diverticulum is in the ascending or descending portion of the duodenum,

XUM

this portion is mobilized after the method of Kocher (Figs. 2 and 3). However, if the diverticulum is in the transverse portion, the duodenum is mobilized and exposure made after the method of Vautrin and Fourche (Figs. 4 and 5). Another approach is

Fig. 2. Mobilization of the descending portion of the duodenum after the method of Kocher. Redrawn from Kellogg

through the transverse mesocolon and the posterior peritoneum (Fig. 6).

We believe that excision of a diverticulum is the best method, although one may be forced to invaginate the diverticulum if excision would compromise the patency of the ampulla of Vater. When the diverticulum is to be excised and has a wide base, it is best to do so by an open operation and to inspect the lumen of the duodenum. Careful closure with two layers of fine chromic catgut gives excellent results with minimal incidence of duodenal fistula or obstruction. If there is only a small pedicle to the diverticulum, a close suture technic is satisfactory after doubly clamping the pedicle and excising the diverticulum.

Two illustrative cases are presented which seem to have been improved following surgery.

Case 1. Duodenal diverticula between the ascending and descending portions of the duodenum with phytobezoar of the diverticulum. Mrs. L. R., 62 years old, was admitted to St. Elizabeth's Hospital with the chief complaint of being "unable to get her food down" for approximately ten years. She stated that the food went part of the way, stopped, and came back. Prior to her admission, she had noticed that the condition had become progressively worse and she was regurgitating more and more of her food. In spite of this she had had no weight loss. Ten years prior to the present illness she had had a cholecystectomy for cholecystitis and cholelithiasis and she dated her symptomatology from the time of that operation. A complete gastrointestinal series was done, which showed only slight retention of the gastric contents, but between the ascending and descending portions of the duodenum a large diverticulum several cm. in diameter was noted. The diverticulum filled along the periphery but not in the center (Fig. 7). Six hours after the ingestion of barium there was some retention of the barium meal in the stomach and a marked density of the central portion of the diverticulum. The physical examination was essentially negative. The patient was advised to have the diverticulum excised. At operation the usual approach was made, the duodenum was exposed, and the adhesions present from

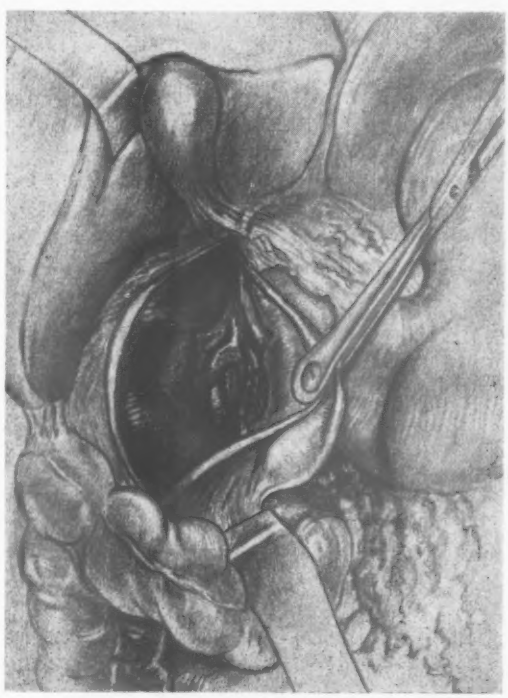


Fig. 3. Mobilization of the descending portion of the duodenum after the method of Kocher. Redrawn from Kellogg

XUM

previous surgery which bound down the duodenum to the under surface of the liver were separated. The duodenum was then turned medially and a large diverticulum was found between the ascending and descending portions on the posterior surface of the

Fig. 4. Exposure of the transverse duodenum after the method of Vautrin and Fourche. Redrawn from Kellogg

duodenum. The diverticulum was opened and excised. On placing the finger inside the duodenum it was found that the diverticulum was of the pantaloon type, there being one diverticulum below the entrance of the common duct and another above the entrance of the common duct. The common duct thus opened directly between the two diverticula. A large amount of foreign material was found in the superior diverticulum and, when removed, appeared to be vegetable material or phytobezoar. A small probe was placed through the ampulla of Vater so that the sutures would not encroach on the lumen. The diverticulum was resected and the duodenum then closed with two rows of continuous chromic catgut sutures. This seemed to give satisfactory closure without blocking the common duct. A drain was placed down to the region of the common duct and brought out through a stab wound. The specimen consisted of a diverticulum measuring 3 x 2½ cms. which contained a phytobezoar measuring 2½ x 2 cms. Follow-up for six months revealed this patient to be improved and free of her symptomatology, and there has been no recurrence of her symptoms.

Case 2. Diverticulum of the descending portion of the duodenum. Mr. R. E. B., 61 years old, was admitted with the chief complaint of pain in the upper abdomen. One week prior to admission he had suffered from severe nausea and vomiting. He was seen by his local physician, prior to his admission, who advised a gastrointestinal series. This showed a large diverticulum in the descending portion of the duodenum. Examination showed the patient to be under-weight. There was a slight tenderness in the upper right quadrant of the abdomen, as well as a right and left inguinal hernia. A review of the roentgenograms showed a shadow overlying the descending portion of the duodenum. When the barium reached this point it filled out the shadow and the shadow measured 3 x 7 cm. (Fig. 8). There was no obstruction to the passage of the meal at that point and the rest of the duodenum appeared normal. Three hours later barium was noted in the diverticulum (Fig. 9). This patient was operated upon, the abdomen being opened in

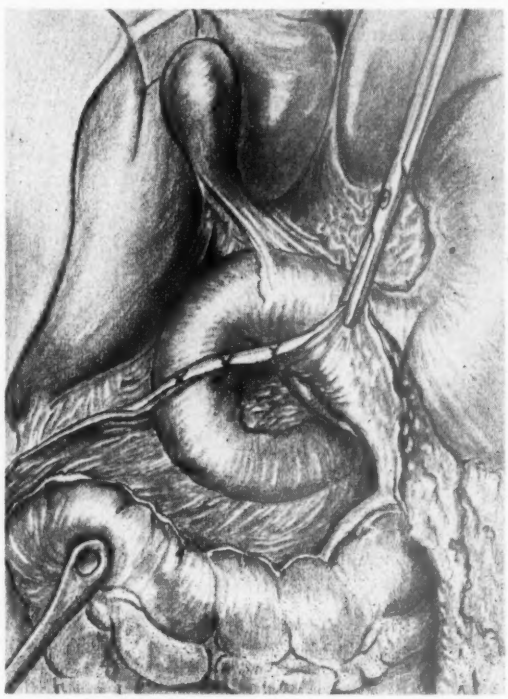


Fig. 5. Exposure of the transverse duodenum after the method of Vautrin and Fourche. Redrawn from Kellogg

the usual manner and the duodenum mobilized medially. A large diverticulum was found arising in the posterior portion of the descending duodenum

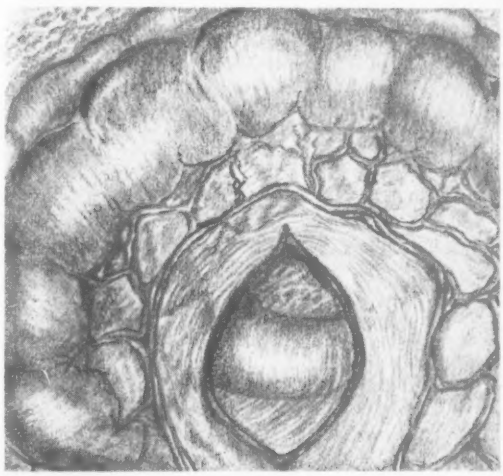


Fig. 6. Exposure of the transverse duodenum through the transverse mesocolon.

from a rather small stalk. The base of the diverticulum was doubly clamped and divided and the stump was sutured with chromic catgut. It was re-

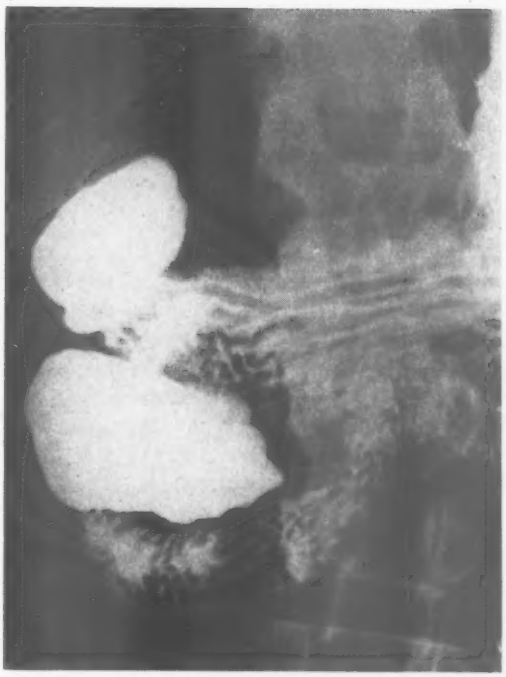


Fig. 8. Case 2. The large duodenal diverticulum is shown.

Fig. 7. Case 1. The diverticulum is shown and contains both barium and food.

Fig. 9. Case 2. Six hours examination showing diverticulum still filled with barium.

inforced with a row of interrupted chromic catgut. The raw surfaces were reperitonealized and the abdomen was closed in the usual manner. The specimen consisted of a large duodenal diverticulum measuring 6 x 5 x 2 cm. and containing food particles, namely, fruit peels, corn, and other partially digested food. Follow-up for eleven months revealed the patient to have made an uneventful recovery and to be free from his symptomatology.

SUMMARY AND CONCLUSIONS

A review of the experiences at St. Elizabeth's Hospital with duodenal diverticula is presented. The anatomy, surgical indication, and operative technic are given. Two cases are reported which were improved by surgical excision of the diverticula. Of the forty-three cases reviewed, only five required surgery for the relief of symptoms.

REFERENCES

Byerly, William L., Jr.: Duodenal Diverticulitis with Perforation, Surgery, **25**:441-445, 1949.

Chamberlain, Digby: Duodenal Diverticula, Brit. J. Surg. **37**:83-85, 1949.

Davis, T. Dewey, and Budd, Samuel W.: Duodenal Diverticula, S. Med. J. **43**:614-617, 1950.

Dunstan, Edgar M.; Lowance, Mason I.; and Jones, Eugenia C.: The Clinical Importance of Duodenal Diverticula, S. Med. J. **42**:460-467, 1949.

Kellogg, Edward L.: Surgical Monographs: The Duodenum, New York City, 1933, Paul B. Hoeber, Inc., pp. 20, 221-241, 628-632.

Mahorner, Howard, and Kisner, Wendell: Diverticula of the Duodenum and Jejunum—with a Report of a New Technical Procedure to Facilitate Their Removal and a Discussion of Their Surgical Significance, Surg., Gynec. and Obst. **85**:607-622, 1947.

617 West Grace Street.

Factbook on Medical Education.

Current statistics on medical education in the United States have been compiled in a convenient pocket-sized booklet for handy reference to be distributed early in April by the American Medical Association. Information contained in the "Factbook on Medical Education" is based on a report made by the Council on Medical Education and Hospitals during the academic year 1951-52. Written in an easy question-and-answer style, the new booklet gives information on enrollments, financial support, faculty and new medical schools. The booklet will be distributed to state and county medical society officers, AMA delegates and officers, newspaper and magazine writers, and allied health organizations. Additional copies will be available for distribution by state and county medical societies.

Former Medical Officers Surveyed.

In analyzing 467 questionnaires returned by former armed forces medical officers, the Council on National Emergency Medical Service has extracted pertinent data on percentage of time spent in treatment of military personnel and their dependents, staffing conditions and the number of physicians willing to remain in service.

The survey of former army, navy and air force physicians shows:

(1) *Percentage of time:* Between 44% and 54% of total overseas time was spent in treatment of military personnel and between 39% and 53% of total domestic time. Treatment of dependents took between 19% and 28% of overseas time and between 25% and 44% of domestic time.

(2) *Staffing conditions:* Overstaffing—136 replies—ranged from 15% to 44%. Understaffing—79 replies—ranged from 15% to 28%. Adequate—227 replies—ranged from 42% to 58%.

(3) *Willing to stay in service:* 214 replied yes; 236 no.

RESECTION RECONSTRUCTION OF THE FEMORAL HEAD*

E. D. VERE NICOLL, M.D.,
Orthopedic Department, University of Virginia Hospital,
Charlottesville, Virginia

During the last 18 months 19 operations have been performed in the University of Virginia Hospital or in the Western State Hospital for reconstruction of the femoral head in cases of osteoarthritis and fracture of the femoral neck.

RESECTION RECONSTRUCTION OF FEMORAL HEAD		
Osteo Arthritis	9 cases	(no mental patients)
Acute Fracture	7 cases	(4 mental patients)
Old Fracture	4 cases	(2 mental patients)

Owing to the small number of cases we are not in a position to recommend any of the following procedures with any degree of certainty but this report of our experiences, successes, and failures may be of interest.

We have done 8 operations for osteoarthritis of the hip and in this group we have gotten our best results. We have followed the technique described by Robert and Jean Judet, although in some of these cases we used a vitallium prosthesis rather than acrylic resin as described by Judet. We used an anterior approach to the hip joint, the incision extending from the anterior superior iliac spine vertically down the thigh for approximately 6 inches. We approached the capsule of the joint lateral to the rectus femoris and sometimes found it necessary to divide the reflected head of rectus femoris and in some cases we divided part of the belly of the tensor fasciae femoris. We used a cruciate incision in the capsule of the joint, making the vertical cut as near to the acetabular rim as possible with the horizontal cut in the line of the neck of the femur.

We found it easier in most cases to osteotomize the head of the femur just proximal to the junction of the head with the neck rather than trying to dislocate the head of the femur from the acetabulum. The head of the femur is then removed using the special appliance described by Judet, after dividing the ligamentum teres. It is important to maintain full length of the femur in order to prevent shortening of the limb with subsequent lip. We found it necessary to reem the acetabulum only in those cases where it was extremely rough or where the superior surface of the acetabulum was not horizontal. After applying the prosthesis to the neck of the femur, after the manner described by Judet, the new head was then rearticulated in the hip joint and the capsule repaired. We believe that it is important that the new prosthesis should fit the acetabulum snugly. If it is too small, an area of sclerosis is liable to develop in the upper part of the acetabulum which bears most of the weight.

Post-operatively we found it necessary to treat the patients in internal rotation and this we did in most cases using a modified Russell's traction with an internal rotating bandage around the knee. We found this more satisfactory than trying to use a plaster cast with a bar to keep the leg in internal rotation. When we used this method we found that if the patients turned over in bed they were liable to get stuck even in external rotation.

Occasionally, while doing this operation, it is difficult to judge the exact angle at which to drive in the prosthesis and when this difficulty is encountered we have used a guide wire applied to the neck of the femur followed by an x-ray to ascertain its exact position. The guide wire may then be removed and the prosthesis put in a comparable position.

During the operation it is necessary to avoid damaging the lateral cutaneous nerve of the thigh and the nerve to vastus lateralis which crosses the incision in its lower part.

We have done some cases for acute fracture of the femoral neck, in very disturbed mental patients at the Western State Hospital. These patients were so disturbed that any form of post-operative treatment would have been extremely difficult to arrange, and it was thought that a Judet type of arthroplasty might give the best chances of a reasonably good result.

One case was done for a subcapital fracture of the neck of the femur of the vertical type, and one was done for a badly comminuted fracture of the femoral head. And still another case was done for a fracture of the neck of the femur after Smith-Petersen nailing had failed. Generally speaking, we believe

*Read before the annual meeting of The Medical Society of Virginia, in Richmond, September 28—October 1, 1952.

XUM

X-Ray No. 1. Avascular necrosis of femoral head following fracture of the femoral neck. Replacement of the femoral head with an acrylic resin prosthesis. The neck is reinforced with a stainless steel bar and this is the only part of the prosthesis which shows in x-rays.

it may be that the operation should, at this time, be reserved for the elder patients, as we do not know how these hips will do after many years of use.

Some of these operations for acute fracture of the neck of the femur show considerable new bone formation in the region of the superior part of the acetabulum after the operation and we wonder whether possibly this operation should be reserved for those cases of fracture of the neck of the femur with non-union established.

In some of our more disturbed patients we got fairly good results in spite of the fact that the patient got up and walked about on the prosthesis the day after the operation. Dr. Stinchfield recommends the use of oxycellouse to prevent bone formation in the region of the hip joint and we believe it may be of advantage to use cortisone post-operatively in order to prevent new bone formation but we think this should not be given for 10 days in order to allow the soft tissues to heal.

In cases of ununited fracture of the femoral neck with absorption of the neck we believe it will be

X-Ray No. 2. Fracture dislocation of the femoral head with fragmentation. After replacement of the femoral head with an acrylic resin prosthesis considerable adventitious bone developed in the region of the capsule limiting movement, and causing pain.

better to use a prosthesis which has a neck attached so as to give the correct length to the neck of the femur. This we have not done but we mean to try it in the future. In two of these cases we have used a prosthesis made in the hospital from acryllic resin, and a Smith-Petersen type of 3 phalanged nail, the nail being inserted down the shaft of the femur. One case was done on a mental patient, but, unfortunately, owing to her picking at the wound she developed sepsis in the region of the nail and the whole prosthesis had to be removed. In the second case an old colored man was treated in the same way with gratifying results. In one case we were confronted with a post-operative dislocation of the hip. This was due to the fact that a lateral incision was made and the greater trochanter removed with an osteotome. The trochanter was not subsequently firmly fixed to the femur and displaced upwards. This case needed a second operation to replace the dislocation and repair the greater tuberosity to the femur. She was subsequently treated in a hip spika plaster, and has made fairly good progress since that time. We have endeavored in these cases to obtain stability of the hip rather than a great degree of movement but it is possible with a new form of prosthesis, which is now available, that greater movement may be obtained.

I believe for this operation to be a success the

most essential factor is complete cooperation of the patient, for in those patients who are incapable of performing post-operative exercises or who have become so used to having a crippled hip that they are not capable of rehabilitation the results will be poor.

The acetabulum should not be reemed unless it is so distorted that the prosthesis will not fit accurately. It is our feeling at this time that osteophytes in the region of the acetabulum should be left alone unless very large. Their removal may predispose to the formation of adventitious bone around the capsule of the joint which is the main single reason for those bad results which have occurred in our series.

RESULTS

In assessing our results we have given patients marks between 0 and 6 for pain, movement, and ability to walk, those with much pain getting 0, those with none getting 6 and so on and the results are set out in the accompanying tables.

OSTEO ARTHRITIS

	Pain	Movement	Walk	Total
1. Mrs. W. J.	4	4	2	10
2. Mrs. T. V.	2	3	2	7
3. Mrs. C. W. A.	6	6	3	15*
4. Mr. W. A. C.	6	4	2	12
5. Mr. M. O. B.	6	4	5	15
6. Miss M. E. W.	3	2	2	7
7. Mr. G. E. T.	5	4	3	12
8. Mr. J. A.	3	0	3	6
9. Mrs. R. S. P.	2	0	1	3

ACUTE FRACTURE OF FEMORAL HEAD

	Pain	Movement	Walk	Total
10. Mr. C. P. W.				
11. Mrs. D. C.	3	3	2	8
12. Mr. R. E. I. (m)	6	4	4	14
13. Mrs. J. P.	3	1	2	6
14. Mrs. M. S. D. (m)	2	2	1	5
15. Mrs. M. A. (m)	6	6	0	12
16. Mrs. C. D. (m)	4	3	1	8

(m—mental patient)

NON-UNION OF FRACTURED NECK OF FEMUR

	Pain	Movement	Walk	Total
17. Mrs. H. W. E. (m)	4	3	2	9
18. Miss E. L. S.	Infected and removed			
19. Mrs. M. B. E. (m)	3	2	2	7
20. Mr. A. C.	4	3	4	11

(m—mental patient)

SUMMARY

	Excellent (Over 14)	Good (9-14)	Poor (5-8)	Failed (Under 5)	Unknown
O. A.	2	3	3	1	0
Ac. Fracture		2	3		
Old Fracture		2	1	1	0

ADDENDUM BY AUTHOR

*Since this paper was written case #3, Mrs. C. W. A. became infected and eventually the acrylic prosthesis was removed two years after its insertion. We are now using only the metallic prosthesis and have had no other case of severe infection.

Parke, Davis & Company

Has opened a new branch office and manufacturing laboratory in Havana, Cuba, where the firm has had a branch office since 1916. Last month, the firm opened a large manufacturing operation in Buenos Aires, Argentina.

Besides Buenos Aires and Havana, the company has Latin American branches and plants in Rio de Janeiro, Colon (Panama), San Juan, P.R., and Mexico City.

XUM

PANCREATITIS*

J. ROBERT MASSIE, JR., M.D.,
Richmond, Virginia

This discussion will concern only the various types of pancreatitis, namely acute hemorrhagic, necrotizing, edematous, and chronic relapsing varieties treated at St. Luke's Hospital during the past four years. Twenty-four cases of this disease were admitted to this hospital during the stated time, making pancreatitis occurring once for every 644 admissions. Three case reports will be briefly presented. No tumors will be discussed. All varieties of pancreatitis are included.

Function of the Pancreas. This organ has both an external and an internal secretion. The external secretion comes from the acinar cells which produce pancreatic juice and is emptied into the duodenum from the ampulla of Vater. Its pH varies from 7.1 to 8.2. The pancreatic juice flow varies from time to time and is stimulated by the flow of acid chyme from the stomach into the duodenum, and by stimulation of the vagus nerves. The digestive factors in the juice are trypsin, lipase and amylase which digest proteins, fats and carbohydrates, respectively. The internal secretion is insulin.

Etiology. Most authors think that associated biliary tract disease and alcoholism are the chief causative factors. Any condition which causes obstruction to the pancreatic ducts, or which causes reflux of bile up the pancreatic tree can cause pancreatitis. Thus, spasm of the sphincter of Oddi, stone in the ampulla of Vater, sudden forceful contraction of the gall bladder, or any other obstruction of the pancreatic ducts are all etiologic agents.

Injuries, sometimes of a trivial nature, can occasionally be a cause of pancreatitis, either mild or severe. Injuries to the pancreas are most common during gastric surgery, but can occur during any type of abdominal surgery.[1]

Pathology. The escape of pancreatic juice into the interstitial tissue through the acinar cells as a result of obstruction may cause edema, fat necrosis, or vascular necrosis with hemorrhage, the severity depending on the amount of pancreatic juice which has escaped. Thus we can understand that all the varieties of pancreatitis are essentially the same, varying only in the concentration and activity of the lipolytic and proteolytic ferments which have escaped from the ducts. The pathology of chronic pancreatitis is only the end-result of an acute process showing an increase in the fibrous connective tissue, and sometimes calcification.

The drainage from a sloughing or necrotizing pancreas is typical and is little mentioned in the literature. Whenever one sees small black particles resembling ground black pepper in the drainage material, it is almost diagnostic of acute or sub-acute pancreatitis which is sloughing. All cases reported here which had drainage presented these same characteristic black particles.

Clinical Features. The severity of the symptoms varies with the type of pancreatitis and the severity of the disease. However, there are certain features common to the several types. The onset is usually sudden with pain in the upper abdomen, frequently radiating to the mid-back, and with tenderness over the upper abdomen along the course of the pancreas and occasionally in the left costophrenic angle. Vomiting is usually present. In those cases of extensive necrosis or hemorrhage, the picture of shock can be added. These patients are critically ill and may die within a few hours unless adequate treatment is administered promptly. On the other side of the picture are those mild cases who are never seriously ill and who apparently get well spontaneously, or merely with starvation and observation. The clinical picture of chronic relapsing pancreatitis is of recurrent episodes of those findings mentioned above which are common to all types of pancreatitis. To these are added more signs of pancreatic damage such as diabetes, undigested fat in the stools, and a chronically ill patient with progressive weight loss.

Diagnosis. Though the disease may frequently be suspected, the fact remains that there are only three ways of making a positive diagnosis of pancreatitis. The first and most important, though not completely accurate, method is by finding an elevation of the serum amylase or serum lipase which results from occlusion or rupture of the duct system. It is usually thought that when the serum amylase determination

*Read before the annual meeting of The Medical Society of Virginia, in Richmond, September 28—October 1, 1952.

is found to be about twice normal, then pancreatitis is probably present. Unfortunately, the amylase does not always become elevated even in cases of severe pancreatitis, as illustrated in the cases to be reported. A high serum amylase determination is of immense diagnostic value, while a normal finding may mean nothing. Unfortunately, there are other causes of an elevated serum amylase, such as renal retention, perforation of the duodenum, obstructive lesions of the salivary ducts, suppurative salivary adenitis, cancer of the pancreas and acute biliary tract disease. Since there are so many other conditions that cause a serum amylase elevation we cannot completely rely on this laboratory procedure as a certain diagnostic test. We, therefore, consider a twice normal serum amylase determination to be highly suggestive of acute pancreatitis, provided the above mentioned disease entities can be eliminated. The higher the amylase determination, the more positive one can be of the diagnosis of pancreatitis.

The second way of positively making a diagnosis is by operation and finding evidence of fat necrosis and/or enlargement and abnormal pancreas.

The third method is by finding evidence of calculi or calcification in the pancreas by x-ray. This is most helpful in the chronic relapsing variety.

The differential diagnosis is mainly between a perforated or a perforating peptic ulcer, acute cholecystitis, acute gastritis, and acute diverticulitis, though many other diseases can be confusing. It is difficult at times to differentiate between biliary tract disease and acute pancreatitis since a normal gall bladder may not fill or be visualized by the Graham-Cole test during an episode of acute pancreatitis, only to appear normal by this test a few days or weeks later.[2]

Laboratory Findings. As previously mentioned, an elevated serum amylase is most important. There is often a high leucocytosis, with a marked shift to the left. Calcium determinations are of no value in early diagnosis. Hypocalcemia only occurs late in the disease. Hyperglycemia occurs if there is an associated diabetes. The urine will show lipolytic or proteolytic substances, and sugar, if diabetes is present. Profound electrocardiographic changes may occur, thus simulating acute coronary disease, but this returns rapidly to normal as improvement is noted in the progress of the pancreatitis. Albuminuria has not been constant.[3]

Treatment of Acute Pancreatitis. When the diagnosis has been established by finding an elevated serum amylase and by excluding other conditions of the upper abdomen, the first therapy should be directed towards the correction of hemoconcentration and electrolyte imbalance by the administration of plasma, blood, and salt solution. Pain should be relieved by demerol in large doses. In those severe cases where the pain cannot be relieved, a sympathetic novocain nerve block is of real value, and can be repeated at will. The stomach should be kept empty either by constant suction and/or by complete starvation. This is of real importance, both because of severe vomiting which is usually present, and also because food and acid passing from the stomach into the duodenum cause increased flow of the pancreatic juices in ducts which are already obstructed. Banthine is of real value at times by decreasing the pancreatic activity. Diabetes should be looked for and treated if present. Surgery should be reserved for those patients who show evidence of jaundice, and for those who develop acute suppurative processes and other complications. Those cases who present more of the clinical features and findings of acute gall bladder disease, such as acute tenderness and possibly a mass in the gall bladder area, should be operated upon promptly in spite of an elevated serum amylase, because the acute pancreatitis is probably caused by the biliary tract disease and removal of the cause should be prompt. When the diagnosis is uncertain and the serum amylase is normal, exploration is at times necessary and important. When this is necessary, the gall bladder should be drained if it is distended. Should the gall bladder and common duct appear normal, I have not done a cholecystostomy, but have merely placed drains to the region of the pancreas.

Rush and Cliffton[4] have shown that an elevation of proteolytic activity in the serum of dogs appears to be a principal factor in the initial shock of acute pancreatitis. They also showed that a substance called SBI, derived from soy beans, which is an antiproteolytic substance, is capable of specifically counteracting the elevation of the serum proteolytic activity, and may have a considerable potential value in the clinical treatment of acute hemorrhagic and necrotizing pancreatitis. The dosage is at the present time uncertain, and is extremely important, since SBI exerts a powerful anticoagulant effect. Further

XUM

experimental work is necessary on the drug before it can be used clinically.

Treatment of Chronic Relapsing Pancreatitis. These patients can rarely be carried for long periods on conservative therapy such as anti-spasmodics, Banthine, etc. Pancreatectomy seems not the procedure of choice, because of the high mortality and morbidity rates. Instead, efforts are directed towards relieving pain and towards decreasing the amount of flow of the pancreatic juices. This is best done by performing a bilateral celiac ganglionectomy. Another method is by unilateral or bilateral lower dorsal sympathectomy, and by vagotomy to decrease the flow of juices. The sympathectomy is done on the side with predominant pain, and, if the patient is not relieved, then the other side is operated upon. Richman and Colp[5] have described three cases completely relieved by subtotal gastric resection and vagotomy, all being made completely symptom free, although one died a few months later from his diabetes. The resections were of the Billroth II type, thus preventing acid chyme from entering the duodenum. In those cases presenting jaundice due to chronic pancreatitis, the free flow of bile into the intestine should be first established. This is done either by anastomosis of the gall bladder to the duodenum, or by sphincterotomy of the sphincter of Oddi and prolonged drainage of the common bile duct, using a long T. tube.

Statistics. Of the twenty-four cases, nine were males and fifteen females. The youngest was twenty-six years and the oldest was seventy-three, with most cases occurring during the fourth and fifth decade. Six cases imbibed freely of alcohol, fourteen would take a social drink, and four used no alcohol. Only one of the twenty-four developed diabetes. Six were of the chronic relapsing variety and eighteen were acute. Of the acute cases, eight were of the severe hemorrhagic or necrotizing types, and ten were of the milder or edematous forms. In the eight proven severe cases, only five had substantial rises of serum amylase. Of these eight cases, all had to be operated upon at one time or another, either to drain a suppurative process, because of obstruction to the GI tract, to correct jaundice, because of an uncertain diagnosis, or because of an accompanying acute cholecystitis and cholelithiasis. Cholecystectomy was done only in the presence of acute cholecystitis. Cholecystostomy was not performed in any case.

Of the six chronic relapsing cases, three have been carried fairly satisfactorily on non-operative management, and three have required operative procedures. Of the operative procedures, one was a bilateral celiac ganglionectomy, vagotomy, and sphincterotomy of the sphincter of Oddi; the second was a sphincterotomy for jaundice; and on the third case a gastroenterostomy and cholecystogastrostomy were done because of duodenal and common duct obstruction. There has been no fatality in any of the cases reported.

CASE REPORTS

Three cases are briefly reported.

Case 1. (J.F.) A forty-seven year old white female was first admitted on February 10, 1950, complaining of a severe pain in the epigastrium, radiating to the upper left quadrant with nausea and anorexia, but no vomiting. She imbibed in alcohol only in an occasional highball. Examination revealed tenderness and fullness in the entire upper abdomen. The admission temperature was 102°. A complete work-up, including GI series, cholecystogram, intravenous pyelogram, and all laboratory procedures, were normal, except for a mild leucocytosis. The serum amylase was forty units. The temperature gradually receded and she left the hospital much improved in two weeks.

She was again admitted on July 15, 1951, with the same complaints and findings as before, though she was much sicker. Again she had a normal serum amylase. After ten days a mass developed in the right abdomen, an abscess with multiple areas of fat necrosis being found, and a sloughing pancreas, which was drained. The pancreas was very large and hard. The gall bladder was not disturbed as it appeared normal. Following this, she developed a right subhepatic abscess which also was drained. It contained similar material to that found in the first abscess. She then improved steadily, the temperature gradually receding from a peak of 105° to normal in three months. She left the hospital four months after admission, still draining particles of pancreatic slough as evidenced by the ground black pepper appearance of the drainage. In January, 1952, the sinus was irrigated with Varidase (Strepto-kinase-Streptodornase) solution and drainage promptly ceased. She has been well ever since and shows no evidence of diabetes. Severe hemoconcen-

XUM

tration was present during the early part of her hospitalization, which was treated by fluids, plasma and blood.

This case represents a typical patient with acute necrotizing pancreatitis. It further demonstrates the lack of dependability of a serum amylase determination, since all readings here were within normal limits, in spite of the presence of very extensive disease. The use of Varidase (Strepto-kinase-Streptodornase) solution worked beautifully in the removal of slough or necrotic material.

Case 2. (M.H.A.) A fifty year old white female, and a non-alcoholic, was admitted on November 12, 1951, complaining of severe pain in the upper abdomen, nausea and profuse vomiting. Examination showed a normal temperature in a slightly jaundiced patient with typical findings of an acute cholecystitis and with a palpable and tender gall bladder. There was also acute tenderness along the entire course of the pancreas and to a lesser extent in the left flank. She was quite ill but in no clinical shock. The laboratory revealed a serum amylase of 112 units, a leucocytosis of thirty-two thousand, with ninety-seven per cent polymorphonuclears and a bile index of eighteen units. Surgery, done on the day of admission, revealed a severe acute cholecystitis and cholelithiasis and a marked dilation of the common duct which contained twenty-six cholesterol stones about the size of green peas. After removal of the stones, a catheter was passed with ease into the duodenum. The pancreas was markedly enlarged and hard, and multiple areas of fat necrosis were seen. Her convalescence was normal and she left the hospital in sixteen days. She was well until July 8, 1952, when she was again admitted with acute upper abdominal pain resembling pancreatitis and had a serum amylase of one hundred and thirty units but no elevation of the icteric index. This attack promptly subsided on starvation and Banthine. No diabetes was present.

This case represents acute pancreatitis occurring secondary to acute biliary disease and is the type that we believe should have prompt surgery in spite of a significant rise in the serum amylase. The last attack probably indicates chronic relapsing pancreatitis.

Case 3. (A.F.H.) A thirty-six year old white female was first admitted on November 9, 1951, with severe right-sided abdominal pain and profuse nausea and vomiting. Alcohol was limited to a social drink. Past history revealed repeated similar attacks for three years with multiple hospitalizations and never a positive diagnosis. A complete work up, including GI series, cholecystogram, intravenous pyelograms, and laboratory procedures including a serum amylase, was all normal except for the fact that the radiologist reported tenderness over a retrocecally located appendix containing a fecolith. Operation through a right rectus incision was done, finding everything normal except for a markedly enlarged right half of the pancreas. The gall bladder was normal and only an appendectomy was done.

She went home in three weeks and for a short period was controlled on Banthine. The attacks recurred and she was readmitted on April 2, 1952, with jaundice of one week duration. The only changes noted from the first admission were the jaundice, emaciation (88 pounds), and calcification throughout the entire pancreas. The serum amylase and blood sugar were both normal. Exploration revealed a dilated common bile duct and gall bladder apparently due to spasm or stricture of the sphincter of Oddi. A sphincterotomy, bilateral celiac ganglionectomy, and a vagotomy were done. The long T tube was removed four months later. Since operation she has done well with no further attacks and now weighs one hundred and eighteen pounds.

This case represents a typical chronic relapsing pancreatitis that could no longer be controlled by medical management. Bilateral celiac ganglionectomy is usually sufficient to both relieve the pain, and to diminish pancreatic secretion, but vagotomy was also done in this case because the nerves were so readily available and for fear the ganglionectomy might not have been complete.

CONCLUSION

In conclusion, the etiology is presumably anything that causes an obstruction of the flow of pancreatic juice, making biliary tract disease the most frequent. The disease occurs almost as frequently in non-alcoholics as in alcoholics. The pathology is basically the same in all the various types of the disease. The diagnosis is made in three ways: (1) by finding an elevation of the serum amylase or lipase and at the same time eliminating other conditions which cause amylase and lipase elevation; (2) by exploration, finding changes in the pancreas or fat necrosis or

XUM

both; and (3) by finding calcification in the pancreas by x-ray.

Treatment of the acute cases should be conservative once the diagnosis is firmly established, with therapy being directed towards correction of hemoconcentration and electrolyte imbalance and towards diminishing pancreatic secretion by reducing the amount of acid chyme entering the duodenum. The exception to this conservative program is in those cases with predominantly gall bladder symptoms. Here we believe prompt surgery should be done to remove the cause of the pancreatitis. Surgery is reserved for the complications which may develop, such as acute suppurative processes, jaundice, obstruction of the stomach or duodenum and pseudocysts. Because of the inability to make a positive diagnosis, it is sometimes wise to explore an acute abdomen for fear of missing a perforation of a hollow viscus. In these cases it seems rarely necessary to drain the gall bladder, but this should be done should any distention of the common duct or gall bladder be observed. If the gall bladder is normal, it should be preserved as it may be useful later in correcting an obstructive jaundice. The use of Varidase solution for hastening the evacuation of necrotic tissue from a sloughing pancreas is highly recommended, having been used with excellent results on two cases by the author.

The treatment of chronic pancreatitis is also nonoperative as long as the patient can be kept comfortable and free from jaundice. If jaundice develops, a sphincterotomy of the sphincter of Oddi or a cholecystoduodenostomy should be done. Bilateral celia ganglionectomy is advisable in cases of uncontrollable pain. I have had no experience with subtotal gastrectomy, and none with vagotomy and bilateral or unilateral lumbo-dorsal sympathectomy, though both seem logical procedures and good results have been reported elsewhere.

SUMMARY

1. The etiology, pathology, diagnosis, complications, and treatment of the various forms of pancreatitis have been discussed.

2. Twenty-four cases occurring in the past four years have been reported, including three in detail, with no mortality.

3. The ground black pepper appearance in the drainage from an abdominal sinus is probably diagnostic of sloughing or necrotic pancreatic tissue.

4. Non-operative surgery is suggested, reserving surgery for the complications.

5. The use of Varidase (Strepto-kinase-Streptodornase) or some other similar preparation is recommended as an adjunct towards quicker removal of necrotic tissue from chronically draining sinuses of the pancreas.

REFERENCES

1. Warren, K. W.: Management of Pancreatic Injuries, S. Clin. North America, 789-801 (June) 1951.
2. Silvani, H. L., and McCorkle, H. J.: Bull. Am. Coll. Surgeons, **32**:248, 1947.
3. Trout and Albertson: Virginia M. Monthly, **76**:532, 1949.
4. Rush and Cliffton: Surgery, **31**:349, 1952.
5. Richman, A., and Colp, R.: Chronic Relapsing Pancreatitis, Ann. Surg. **131**:145, 1950.

McGuire Clinic, St. Luke's Hospital.

Supplement to A.M.A. Film Catalog Now Available.

The A.M.A. Committee on Medical Motion Pictures has announced the publication of a supplement to the list of films available through the motion picture library. This supplement includes 12 motion pictures added to the library since publication of the December 1, 1952 catalog. Copies may be obtained by writing to the committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn, Chicago 10, Illinois.

XUM

GALACTOSEMIA

McLEMORE BIRDSONG, M.D.,
and
JAMES B. WOOD, M.D.,*
Charlottesville, Virginia

Galactosemia (galactose diabetes) is a disorder of carbohydrate metabolism in infancy, characterized by retarded mental and physical development, failure to gain, cataract formation, hepatomegaly, albuminuria, and the presence of the reducing substance, galactose, in the urine. Galactosemia is due to the inability of the body to metabolize properly ingested galactose.

The first case was reported in 1908[1] by Von Reuss, and the first case in American literature appeared in 1935.[4] To 1951 there were only 20 cases in the literature, but the fact that the condition is being reported with more and more frequency would suggest that galactosemia is not as rare as was formerly thought but rather is being recognized more readily. Since the disease is easily cured by elimination of galactose from the diet, the importance of early diagnosis is obvious if life is to be saved, as these patients die of severe malnutrition, secondary infection and cirrhosis of the liver.[19]

The diagnosis is suspected with the onset of the above symptom complex. The onset may occur shortly after birth but the presence of the disease state may not become apparent for several weeks or months after birth. Galactosemia should be suspected in all infants showing marked malnutrition. If hepatomegaly, cataracts, reducing substances in urine, albuminuria, and, occasionally, an enlarged spleen and jaundice are found in patients with malnutrition, certainly one should consider the diagnosis of chronic galactosemia. Elevated blood sugar will usually be found, and this can be proved not to be glucose by yeast fermentation. The galactose tolerance test will be high and prolonged.

Confirmation of the diagnosis depends on finding and identifying galactose in the urine, which is constant and varies in amount with the intake of galactose in the diet.

There are several laboratory tests available which aid in identifying the urinary reducing substance as galactose. Galactose reduces Benedict's reagent but, unlike glucose, it is not readily fermented by yeast. A positive mucic acid test indicates the presence of either lactose or galactose. Bial's test, if positive, indicates the presence of pentose (and sometimes glucuronates), but not galactose. In addition, Tollen's phloroglucinol test is positive for galactose, pentose and glucuronic acid. Thus, galactose is identified in the urine by the following combination: positive copper sulfate reduction, positive mucic acid test, positive Tollen's test, and negative Bial's test.

With removal of galactose-containing foods from the diet (chiefly milk), there is a prompt subsidence of symptoms and resumption of normal growth and development. Cataracts may disappear entirely. Symptoms recur when galactose-containing foods are again added to the diet.

Case Report: The patient, DWM, was admitted to the University of Virginia Hospital on February 20, 1952, at the age of three weeks, with the referring complaint of abdominal swelling and vomiting. He was born in a neighboring hospital, the third child of normal, healthy parents. The siblings were ages six and three years and were well. Pregnancy and delivery were said to have been normal. Birth weight was 9 lb. 5 oz. He had been fed since birth on an evaporated milk formula.

He remained well until about the 6th day of life when he began to vomit. Phenobarbital and a change of formula failed to relieve vomiting and later abdominal distention developed. Both persisted during his 3 weeks' stay there. It was reported to us that several diagnostic procedures were done, which were as follows:

Seven urinalyses showed zero to 3+ albumin, trace to 5% sugar, 3 to 30 WBC, and many coarsely granular casts with each determination. Four white blood counts varied from 6,000 to 20,000 per cubic millimeter. A blood sugar after 4 hours of fasting was 209 mgm./% and after 8 hours of fasting was 189 mgm./%. A blood culture was negative. A chest x-ray obtained on the 13th day of life revealed "increased markings in the left upper lung field" which was interpreted as being diagnostic of atypical pneumonia. Spinal puncture was also performed, the fluid containing only 4 cells and the protein being 32 mgm./%. On the 17th day a gastrointestinal series, done with the hope of determining

*Department of Pediatrics, University of Virginia School of Medicine, Charlottesville, Virginia.

XUM

the cause of the abdominal distention, was negative. A flat plate of the abdomen on the 20th day also failed to reveal evidence of obstruction.

Supportive therapy during this time consisted of glucose, saline and protein hydrolysate solutions subcutaneously, two whole blood transfusions of 60 cc. each, multivitamin preparations orally and intramuscularly, and vitamin K intramuscularly. He also received penicillin, terramycin and streptomycin at various times.

As he failed to improve, he was referred to the University of Virginia Hospital and admitted on February 20, 1952. Physical examination on admission revealed a malnourished, severely ill, three weeks' old white male infant. Temperature was 100.6 rectally and respirations were normal. The weight was 9 lbs., 2 oz. The right ear canal was filled with a serous exudate. The chest was clear and the heart was negative. The abdomen was greatly distended, with fullness in the flanks. Shifting dullness was noted on percussion. The liver was enlarged four finger breadths below the right costal margin. The veins of the abdominal wall were distended. There were large ecchymotic areas of the skin over the lateral thighs, the site of subcutanous injections, and over the femoral regions, the site of femoral venipunctures.

The initial laboratory work was as follows: Blood work revealed a 4.1 million RBC, hemoglobin 13 gm. or 84%, WBC 22,000 with a differential of 9 bands, 55 PMN's, 23 small lymphs, 5 transitional monocytes, 8 degenerated cells. Urinalysis was yellow, slightly cloudy, acid reaction, specific gravity unobtainable because of insufficient quantity, slight trace albumin, 4+ sugar, acetone negative, bilirubin 1+, WBC 4-8 per high power field with a few clumps, 0-1 RBC per high power field, many coarsely granular casts and a moderate number of hyaline and rare fine granular and pus cell casts.

Blood urea was 46 mgm.%, CO_2 with 15.4 meq./1, and blood sugar was 223 mgm./%. Blood culture, Wassermann and Kahn were negative. Chest x-ray was negative and flat and upright x-rays of the abdomen revealed no evidence of obstruction.

Shortly after admission a paracentesis was performed and approximately 80 cc. of cloudy, orange-colored fluid was withdrawn. Laboratory report on this fluid was as follows: reaction alkaline, no clot, specific gravity 1.012, serosa mucin test 1+, sugar 177 mg.%, urea 56 mg.%, WBC 25,000, 90% of which were polymorphs and 10% lymphocytes. B. pyocyaneous was cultured.

On admission the infant was placed on an evaporated milk formula. After the above studies were underway, he was started on chloromycetin palmitate because of the peritonitis. The diagnosis of galactose intolerance was considered and efforts were begun to identify the type of reducing substance in the blood and urine. However, the child ran a rapidly downhill course. Vomiting occurred with frequency and feeding was best accomplished by gavage preceded by aspiration of the stomach. Within 24 hours after admission, his legs, back and face had become extremely indurated and oxygen became necessary to prevent cyanosis. On February 21, approximately 36 hours after admission, the child suddenly expired.

On February 29, the following report was received from the laboratory:

February 20—blood glucose: 43 mgm.%
*non-fermentable reducing substance presumably galactose: 206 mgm.%

February 21—blood glucose: 30 mgm.%
*non-fermentable reducing substance presumably galactose: 113 mgm.%
*The normally occurring 25 mgm.% of non-glucose reducing substances have been subtracted

Identification of galactose in urine:
Fermentation—negative
Bial's test—negative
Mucic acid—positive
Tollen's phloroglucinol—positive
Copper reduction at 55°—negative
Quantity of galactose in aliquot of pooled specimens: 1.5 gm./100 cc.

Post-Mortem Report: The body was that of a white, male infant. There was a marked icterus of the skin. The abdomen was markedly protuberant. There were several bluish, discolored patches on both thighs laterally.

Body Cavities: The subcutaneous fat was somewhat harder in consistency than normally. The abdominal cavity contained about 100 cc. of dark yellow and slightly cloudy fluid. Innumerable white patches covered the mesenterium.

Heart and Lungs: Together they weighed 88

grams. The heart appeared normal. There were two small patches of circumscribed infiltration on the surface of the lung which appeared to be abscesses.

Spleen: The spleen was enlarged and weighed 23 grams. It was covered by a fibrous exudate. At 3 points there were circumscribed lesions which appeared to be infarcts.

Liver: The liver weighed 250 grams. It was markedly enlarged, somewhat hard, and jaundiced. It had a dark green color. In the lower part of the hepatic veins there was a thrombus which was thought to be antimortem. Similarly, other thrombi were present in the larger and smaller branches of the hepatic artery.

The gallbladder and gastrointestinal tract appeared normal.

Pancreas: In the head of the pancreas there were two small yellowish spots, each approximately 0.5 cm. in diameter which were thought to represent abscesses. The pancreatic vessels were thrombosed.

The adrenals, kidneys and brain appeared perfectly normal.

The positive *microscopic findings* were as follows:

Liver: There was a very marked biliary cirrhosis. The liver cells showed an extreme fatty degeneration. There was a fair amount of bile pigment in the liver cells and a large amount in the Kupffer cells. On the surface of the liver there was an abscess which seemed to have originated from a septic thrombus. Thromboses were present in the intrahepatic part of the hepatic artery. A marked purulent peritonitis was present in the broad ligament around the umbilical vessels.

Spleen: This showed several large abscesses and most likely septic thrombi.

Pancreas: Peripancreatic abscesses and diffuse pancreatitis were noted.

G-I Tract: There was an extensive peritonitis of the visceral peritoneum and also of the mesentery.

Kidneys: The kidneys showed cloudy swelling in the glomeruli and were congested.

Adrenals: These appeared normal.

Skin: The subcutaneous tissue was thickened and edematous.

Bone marrow and brain: Normal.

Bacteriology: Pseudomanas and E. coli were cultured from the peritoneal fluid.

SUMMARY

1. A brief discussion of chronic galactosemia is presented stressing the importance of early diagnosis.

2. Signs, symptoms and laboratory findings of the disease are outlined.

3. Clinical case with post-mortem report is presented.

BIBLIOGRAPHY

1. Von Reuss, A: Zuckerausscheidierg im Sauglingsalter, Wien, med, Wchnochr. **58**:799, 1908.
2. Goppert, F.: Galactosuria nach Milchyucgergabe bei angeborenem familiarem, chronischem Leberleiden, Berliner klin. Wchacher. **54**:473, 1917.
3. Fanconi, G.: Hochgradize Galactose-Intolerang bei einem Kirde mit Neurofibromatosis Rechlinghauser, Jahob, f. Kindert. **138**:1, 1933.
4. Mason, H. H., and Turner, M. E.: Chronic Galactemia, Am. J. Dis. Children. **50**:359, 1935.
5. Norman, F. A., and Fashena, G. J.: Chronic Hypergalactosemia, Am. J. Dis. Children. **66**:531, 1943.
6. Mellinhoff, S.; Roth, B.; and MacLaggen, J.: Galactosemia with Hepatic Damage, J. Ped. **27**:338, 1945.
7. Bruck, E., and Rapoport, S.: Galactosemia in Infant with Cataracts, Am. J. Dis. Children. **70**:267, 1945.
8. Goldbloom, A., and Brickman, H. F.: Galactemia, J. Ped. **28**:676, 1946.
9. Goldstein, E. O., and Ennis, J. M.: Galactosemia, J. Ped. **33**:147, 1948.
10. Greenman, L., and Rathbun, J. C.: Galactose Studies in Infant with Idiopathic Galactose Intolerance, Ped. **2**:666, 1948.
11. Bell, L. L., and Watson, J. J.: Lesions of Galactose Diabetes (Galactosemia)—Pathologic Observations, Arch. Path. **49**:393-403, April, 1950.
12. Bell, L. S.; Blair, W. C.; Lindsay, S.; and Watson, S. J.: Galactose Diabetes (2 Siblings)—J. Ped. **36**:427-439, April, 1950.
13. Donnell, G. N., Lann, S. H.: Galactosemia—Report of 4 Cases, Ped. **7**:4, pp. 503-515, April, 1951.
14. DuShare, J. W., and Hartman, E. E.: Galactosemia in Infancy—Report of a Case with Observation for 24 Months. Ped. **7**:5, pp. 679-783, May, 1951.
15. Townsend, E. H.; Mason, H. H.; and Strong, P. S.: Galactosemia and Its Relation to Laennec's Cirrhosis—Report of the Literature and Presentation of 6 Additional Cases. Ped. **7**:6, pp. 760-773, June, 1951.
16. Langewisch, W. H., and Bigler, J. A.: Disorders of Glycogen Metabolism. Ped. **9**: March, 1952.
17. Galactemia with Cirrhosis in Infants, Clinicopathological Reports—U. Va. and M.C.V. Virginia Med. M. **78**:7, p. 368, July, 1951.
18. Human Galactosemia Cataract, Amer. Jour. Ophthalmology. **34**:9, Sept., 1951, pp. 1268-1270. Galactosemia Cataract, pp. 1271-1274.
19. Galactosemia, A Report of Two Cases in Siblings, Pan. Am. M. Woman's J., **59**:23-29; 31-33, May, 1952.

XUM

NAPOLEON'S VIEWS ON THE COMPLICATIONS OF CHILDBIRTH*

CHESTER D. BRADLEY, M.D.,
Newport News, Virginia

With capture by the English Navy staring him in the face, Napoleon threw himself on the mercy of that nation. By this dramatic gesture, the French Emperor hoped to assure for himself a not too onerous imprisonment on some comfortable estate in rural England. However, his realistic captors had other plans for him. They decided that Napoleon must go to the island of St. Helena, far out in the South Atlantic Ocean, from which there could be no easy return, as from Elba. A handful of faithful followers were allowed to accompany the Emperor into his exile. These were the Counts Bertrand, Montholon, Las Cases, and their families, with the Baron Gourgaud and over a dozen servants. However, the French physician, Maingault, who had come with Napoleon from France, refused to follow him to St. Helena. There was no time to get another French physician.

Napoleon then requested that Dr. Barry O'Meara, surgeon of HMS Bellerophon, be assigned as his physician. Apparently the Emperor had taken a liking to O'Meara during the voyage from Rochefort, France, to Torbay, England. O'Meara was a well trained physician, having been educated in Dublin and London. O'Meara spoke Italian, which was Napoleon's mother tongue. In addition, O'Meara was an Irishman. No doubt Bonaparte shrewdly reasoned that since he must have an enemy physician, better an Irishman than an Englishman. France had long intrigued with Irish rebels. Thousands of Irishmen had sought refuge on her soil and had become staunch Frenchmen.

The English authorities were secretly pleased that Napoleon desired an English naval surgeon as his personal physician. They urged O'Meara to accept the position, which he did only on condition he forfeit none of his rights in the English Navy. Dr. O'Meara was frankly intrigued by the opportunity to study this great man at close range. No doubt he hoped to get what we today would call the "inside story" of world-shaking events from the lips of their chief perpetrator. At any rate, O'Meara joined Napoleon's party as his physician and sailed with him on HMS Northumberland, arriving at St. Helena on October 17, 1815, after a voyage of about ten weeks.

To relieve the tedium of exile and to justify himself before the world, Napoleon plunged feverishly into writing his autobiography. He dictated in relays to his companions in exile: Bertrand, Las Cases, Gourgaud and Montholon. When one was exhausted, the other would take his place. Conscious of their historic roles, certain of the companions began to make personal records of their daily life at St. Helena. Not only Bertrand, Gourgaud and Las Cases kept diaries, but two of the servants, Marchand and St. Denis, did likewise. It was inevitable that Dr. O'Meara, with his special interest in Napoleon as a historic character, should also keep a diary. O'Meara began his diary after Napoleon was finally installed at "Longwood," the house prepared for him and his companions.

O'Meara writes: " . . . immediately on retiring from Napoleon's presence, I hurried to my chamber and carefully committed to paper the topics of conversation, with, so far as I could, the exact words used." The physician gives detailed accounts of Napoleon's bickerings with Sir Hudson Lowe, the Governor of St. Helena. He sets down the Emperor's reminiscences of men and events in his career. He reports Bonaparte's ideas about a great variety of subjects including politics, religion, medicine, the dawning machine age, free-masonary, the Irish question, predestination, the English ruling class, and so on. O'Meara's diary, like those of the French companions of the exile, reveals Napoleon's great erudition, the wide range of his interests and the keenness of his mind.

On November 6, 1817, there occurred in England an event which shocked the world and plunged the British Isles into the deepest mourning. The Princess Charlotte, heiress to the throne, died in childbirth. The baby, a boy, was stillborn. The Princess, only twenty-one years old, was highly popular. After a childhood marred by the separation and wrangling

*Read before the Medical Staff, Mary Immaculate Hospital, Newport News, Virginia, March 4, 1953.

of her father, the Prince Regent, and her mother, Princess Caroline of Brunswick, she had been happily married to Prince Leopold.* After an essentially normal pregnancy, the Princess Charlotte went into labor at term, but, due to the inadequacy of the uterine contractions, it took 26 hours for the cervix to dilate. Even then the contractions remained unsatisfactory and the descent of the head was slow. Although the cervix was dilated, the obstetrican in charge, Sir Richard Croft, allowed the Princess to continue in labor an additional 24 hours.

From Masson's *Napoleon at St. Helena*, Courtesy Medill McBride Co.

During the last five or six hours of this 50 hours of labor, the baby's head was on the floor of the perineum. Nevertheless, Croft waited until the baby was delivered by the Princess' own efforts. The child, a nine-pound boy, had evidently been dead for some hours. About 30 minutes after delivery, the Princess had a hemorrhage and Croft inserted his hand into the uterus and brought the placenta down into the vagina. About one hour after delivery the doctor removed the placenta from the vagina, from which it was protruding. This was followed by some more bleeding. Four hours after delivery of the baby, the Princess died with symptoms of hemorrhagic shock. At autopsy about "a pound of blood was found in the cavity of the uterus."

Sir Richard Croft was a son-in-low of the celebrated London obstetrician, Thomas Denman, who had been noted for his pronounced aversion to forceps. Denman had taught that forceps should not be applied unless the head of the baby had been on the perineum for six hours and all uterine contractions had ceased (Denman's Law). This was tantamount to saying that the uterus must be completely exhausted before the use of forceps could be permitted. Denman had also been opposed to removal of the placenta from the vagina unless one hour had elapsed since its descent from the uterus. This policy he also had applied to the retained placenta, Denman's practice having been merely to separate and bring the placenta down from the uterus into the vagina, leaving its final expulsion to the forces of nature. It can be seen, therefore, that Sir Richard Croft in his management of the labor of Princess Charlotte was merely adhering faithfully to the precepts of his father-in-law, Dr. Thomas Denman, who had been dead only two years.

The storm of criticism and abuse heaped on the unfortunate Croft so unnerved him that three months later he shot himself while attending another patient. The case of the Princess Charlotte has recently (1951) been studied by Sir Eardley Holland† in the light of new documents secured by him from the Croft descendants. Sir Eardley has aptly termed the case "a triple obstetric tragedy"—mother dead, baby dead, obstetrician dead.

Although the death of the Princess Charlotte occurred in November, 1817, the news, because of the slow communications of the time, did not reach St. Helena until February, 1818. O'Meara records in his diary: "Communicated this intelligence to Napoleon, who expressed his affliction at the unfortunate event, as, independent of the feelings which naturally arose at the fate of a princess, cut off in the prime of youth and beauty, and with such

*Leopold of Saxe-Coburg (1790-1865), later Leopold I, King of the Belgians, and uncle of Queen Victoria of England.

†The summary of the Princess Charlotte's case given above has been abstracted from Sir Eardley Holland's extremely interesting and very valuable paper.

XUM

prospects before her; he said, that *he had not been without hopes that she would have caused a more liberal policy to be adopted towards himself.*‡ He inveighed against the accoucheurs, and expressed his surprise that the populace had not stoned them to death. He observed that the business had a strange appearance, and that precautions appeared to have been taken to deprive the princess of everything necessary to support and to console her in her first accouchement. He urged that some old married women, who had frequently borne children, ought to have been at her bedside to comfort her. Had they been present, they would have perceived that matters were going on wrong, and would have insisted upon further assistance being rendered. It was unpardonable in the old queen not to have been on the spot. 'What signified Leopold,' said he, 'he is a *garcon* (boy), and knew not what to do.' "

Napoleon then warmed up to his subject and told O'Meara that he himself had once saved his second wife, Marie Louise, from dying in a similar manner during labor. "During the time of her labor, I was in an apartment close by, from whence I went to her room every now and then. After she had been some hours in labor, Dubois, the accoucheur, came to me while I was reclining on the sofa, with great alarm painted on his countenance, and said, 'that the Empress was in a state of great danger, that there was a wrong presentation.' I asked him if he had ever seen anything of the kind before. Dubois replied, 'that he had, but very rarely, perhaps not one in a thousand, and that it was very afflicting to him that so extraordinary a case should happen with the Empress.' 'Forget', said I, 'that she is Empress, and treat her as you would the wife of a little shopkeeper in the Rue St. Denis. This is the only favor I ask of you.' . . . I then accompanied Dubois to the bedside, encouraged and tranquilized the Empress as much as possible, and held her while the forceps were applied. The child was apparently dead when born, but by frictions and other means he was restored to life. His birth produced a delirium of joy in the nation."

‡My italics

In this story we see the workings of a mind which made Napoleon Bonaparte one of the greatest military and administrative geniuses of all time. He analyzes the situation, he decides, and then he acts. Confronted by an obstetrician who is demoralized by the weight of his extraordinary responsibility, Napoleon asks Dr. Dubois whether he has ever encountered the same complication before. Satisfied then of the doctor's ability to handle the case, he tells him, "Forget that she is Empress. Treat her as you would the wife of a little shopkeeper."

Napoleon, a non-medical man, has given us an obstetric maxim which has a universal and a permanent value: *No matter how exalted the social station of the patient, handle her case according to sound obstetric principles.*

BIBLIOGRAPHY

Bradley, Chester D., and Miriam D.: Craven and O'Meara: Medical Boswells to Jefferson Davis and Napoleon Bonaparte, Bull. Hist. Med. XXVI: (March-April) 1952, pp. 141-152.

de Chair, Somerset (Editor): Napoleon's Memoirs (New York, Harper & Bros., 1948), Introduction.

Fleuriot de Langle, Paul (Editor): Napoleon at St. Helena; the Journals of General Bertrand January-May 1821. (New York, Doubleday & Co., 1952), Introduction.

Holland, Sir Eardley: The Princess Charlotte of Wales; a Triple Obstetric Tragedy, J. Obst. & Gynaec. Brit. Emp. LVIII (December) 1951.

Masson, Frédéric: Napoleon at St. Helena (New York, Medill McBride Co., 1950) Introduction; pp. 1-96.

O'Meara, Barry E.: Napoleon in Exile or a Voice from St. Helena (New York, Redfield, 1853), 2 vol., indexed.

2914 West Avenue.

CARCINOMA OF THE PANCREAS— CLINICAL AND LABORATORY OBSERVATIONS IN 29 PROVEN CASES*

JAMES O. BURKE, M.D.,
and
KEMP PLUMMER, M.D.,
From the Department of Medicine, The Medical College of Virginia Hospitals, Richmond, Virginia

Carcinoma of the pancreas is now being considered as a cause of abdominal pain.[1,8] In order to define, if possible, other related symptoms and findings in this disease the records of patients with carcinoma of the pancreas admitted to the Medical College of Virginia Hospitals during the past five years have been reviewed. Only those cases with a proven diagnosis have been included.

Analysis:

1. AGE AND SEX IN CARCINOMA OF THE PANCREAS.
   21 males—50 to 75 years of age—average 61 years
   8 females—50 to 79 years of age—average 67 years
   18 white—12 colored.

2. DURATION OF SYMPTOMS (to admission)
   1 to 60 months—average 12 months.

The more advanced ages of the patients, and the duration of symptoms which average 12 months from onset until admission to the hospital are obviously not of importance for specific diagnosis, and are seen in most cases of carcinoma from internal organs.

3. DIAGNOSIS:

Biopsy	19
Autopsy	9
Metastasis with mass in pancreas	1

4. PATHOLOGY:

Duct cell	3
Adenocarcinoma	25
Head only	3
Body and tail only	6

Biopsy at operation was the method of diagnosis in twenty cases and autopsy in nine. The majority of the patients had adenocarcinoma and this involved the head, body and tail in most cases. There were only three cases of duct cell carcinoma, while there were twenty-five cases of adenocarcinoma. The head was involved in three cases, and the body and tail in only six; sixteen had involvement of both body and head.

5. PAIN IN CARCINOMA OF PANCREAS

Pain as chief complaint	22
Jaundice with mass	3
Jaundice without mass	2
Mass without jaundice	1
Ascites	1

The most important feature in the diagnosis of carcinoma of the pancreas is the recognition of pain, which may be its only manifestation.[3,8] Of these twenty-nine cases, pain was the chief complaint in twenty-two. Abdominal discomfort was present in the other patients who had mass or ascites. Jaundice, with or without mass, was the presenting complaint in five. Some years ago it was held that carcinoma of the pancreas was painless; other writers have called attention to the fact that approximately 90% of the patients with carcinoma of the pancreas have pain.[2,3,4,5,6,7]

6. LOCATION OF PAIN IN CARCINOMA OF PANCREAS —24 cases.

Abdominal	6
Epigastric & R.U.Q.	6
Epigastric & back	4
Epigastric & R.L. Q.	1
Epigastric & left chest & right flank	1
Lower abdominal	1
Lower abdominal & back	1
Flank, one or both	3
Backache	1

It will be noted that the epigastrium was the location most frequently pointed to, but that the right upper quadrant and back appear frequently, and that the flank and chest may also be the sites of pain.[4] The pain is characteristically worse on lying down

*Read in part before the annual meeting of The Medical Society of Virginia, at Richmond, September 28-October 1, 1952.

XUM

—the supine position—and eased to some extent by an upright or sitting position. The pain is usually steady and frequently not uniformly relieved by drugs. Psychiatric features of the disease have been described which appear to be related chiefly to the fact that no cause for the pain is found.[1,9]

7. BOWEL DISTURBANCE IN CARCINOMA OF PANCREAS

Constipation (a change)	7
Nausea and vomiting	3
Hematemesis	1
Melena	2
Not stated	16

Bowel disturbance of some sort appears in the roll of symptoms. Whether constipation here is significant is not known. It probably is a result of anorexia.

8. FINDINGS ON ADMISSION—CARCINOMA OF PANCREAS

Enlargement of liver, mass or ascites without jaundice	5
Jaundice	18
Weight loss with *pain*	6

The physical findings on admission in patients with carcinoma of the pancreas depend upon the time interval and it will be noted that enlargement of the liver, mass or ascites was present without jaundice in five patients, jaundice was present with or without a mass in eighteen, and that in six there was no finding other than that of weight loss, and the patient's complaint of pain. Twenty-six of the twenty-nine patients had weight loss—an average loss of twenty-seven pounds was present when weight was stated. Thrombosis of peripheral venins has been noted frequently in carcinoma of the pancreas and carcinoma of the lung. It is claimed to be due to a diminished production of trypsin.

9. JAUNDICE IN CARCINOMA OF THE PANCREAS

(Admission—Laboratory)

No Jaundice	11
Jaundice	18
Less than 2 mgm. bilirubin	5
Between 2-10 mgm. bilirubin	7
More than 10 mgm. bilirubin	5
Not stated	1

Jaundice in carcinoma of the pancreas is not necessarily severe. More patients were jaundiced than not, but five had serum bilirubin determinations of less than two.

10. X-RAY FINDINGS

Evidence of pressure or irritability	12
Negative barium study	7
No X-ray of G.I. tract	10
Non-functioning gall bladder	6
Normal function gall bladder	3
Calcification of pancreas	1

The X-ray of the gastrointestinal tract and cholecystogram are important for the study of these patients and it will be noted that of those studied, the majority had some evidence of a disease process. Twelve had evidence of pressure on the stomach or duodenum, or irritability of the duodenum. Seven had negative barium studies, and ten were not studied. Six had non-functioning gall bladders to cholecystography. Calcification of the pancreas is a frequent finding in recurrent pancreatitis of many years duration,[10,11,12] but one patient in this series had calcification of the pancreas.

11. HYPERGLYCEMIA IN CARCINOMA OF PANCREAS

Present	7
Not present	8
No blood sugar	15

Of the other laboratory determinations hyperglycemia is a common finding. A number of these patients were first diagnosed as having diabetes mellitus. The explanation for the hyperglycemia is that the islet cells are functionally impaired, either from inflammation, edema or actual carcinomatous invasion. This same finding is seen in patients who have recurrent pancreatitis where the islet cell functional impairment fluctuates.[13,14,15,16] If there is anything unusual about this hyperglycemia it is its mildness. These patients rarely require much insulin. The glucose tolerance test is a better way of demonstrating the potential hyperglycemia. Glycosuria may not always be present.

12. SERUM AMYLASE DETERMINATIONS

Elevated	5
Normal	4
Low	5
Not done	15

The serum amylase of patients with suspected carcinoma of the pancreas has been studied,[17,18,19] and in this group ten of the fourteen patients studied

had abnormal serum amylase determinations. The elevated amylase probably indicates obstruction of the pancreatic ducts, and the low serum amylase which has not been proven to be significant, we believe to be due to a reduction in the glands' capacity to produce amylase.

13. SERUM ALKALINE PHOSPHATASE

Elevated (jaundice)	11
Normal	3

Serum alkaline phosphatase has been reported as showing an elevation in patients with carcinoma of the pancreas,[8] and in the fourteen cases studied eleven had elevated values. Whether this elevation of phosphatase arises from pancreatic tissue or liver tissue is not understood, since in these particular patients jaundice was present. It is our impression, however, that the elevation is due to growth of malignant tissue or to regeneration of cholangiolar or pancreatic duct cells.[20]

14. ANEMIA (admission)

(Less than 75% or 12 gms.)	8
None	17
Not stated	4

Anemia was not prominent in these patients and would appear to be of less significance in carcinoma of the pancreas than in carcinoma of other viscera.

SUMMARY

Pain is the most important early feature in these cases of carcinoma of the pancreas. Peripheral thrombophlebitis occurs late, by which time the diagnosis of some type of carcinoma is usually obvious. The laboratory features which may be present to aid in arriving at a diagnosis of carcinoma of the pancreas in the early course of the disease are:

1. Hyperglycemia to glucose tolerance test.
2. Serum alkaline phosphatase increase; and
3. Serum amylase changes.

The X-ray evidence, while late, may occur at a time when surgery is still helpful.

REFERENCES

1. Pelner, L.: Gastroenterology, **8**:92, 1947.
2. Dashiell, G. F., and Palmer, W. L.: Arch. Int. Med., **81**:173, 1948.
3. Rose, C. A., and Klinge, F. W.: Gastroenterology, **12**:204, 1949.
4. Arkin, A., and Weisberg, S. W.: Carcinoma of the Pancreas—A Clinical and Pathological Study of 75 Cases. Gastroenterology, **13**:118, 1949.
5. Burke, J. O.: The Diagnosis of Diseases of the Pancreas. West Virginia Med. J. **47**:151, 1951.
6. Broadbent, R. T., and Kerman, H.: One Hundred Cases of Carcinoma of the Pancreas—A Clinical and Roentgenologic Analysis. Gastroenterology, February, 1951, **17**:163.
7. Smith, B. K., and Albright, E. C.: Carcinoma of the Body and Tail of the Pancreas—Report of 37 Cases Studied at the State of Wisconsin General Hospital from 1925-50. Ann. of Int. Med., January, 1952, **36**:90.
8. Burke, J. O.: Diagnostic Features of Pancreatitis and Carcinoma of the Pancreas. Medical Times, **80**:690. November, 1952.
9. Elman, R., and Lemmer, R. A.: The Pancreas—Contributions of Clinical Interest Made in 1947. Gastroenterology, **12**:375, 1949. Elman, R., and Butcher, H. R.: The Pancreas—Contributions of Clinical Interest Made in 1948. Gastroenterology, **13**:285, 1949.
10. Gambill, E. E., and Pugh, D. G.: Pancreatic Calcification—Study of Clinical and Roentgenologic Data on 39 Cases. Arch. Int. Med., **81**:301, 1948.
11. Court, D., and Matheson, N. M.: Pancreatic Calculi. Gastroenterology, **10**:848, 1948.
12. Eliason, E. L., and Welty, R. F.: Pancreatic Calculi. Ann. Surg. **127**:150, 1948.
13. Comfort, M. W.: Proc. Staff Meet. Mayo Clinic, **22**: 548, 1947.
14. Sprague, R. G.: Diabetes Associated with Chronic Relapsing Pancreatitis. Proc. Staff Meet. Mayo Clinic, **22**:553, 1947.
15. Maimon, S. N.; Kirsner, J. B.; and Palmer, W. L.: Chronic Recurrent Pancreatitis—A Clinical Review of 20 Cases. Arch. Int. Med., **81**:56, 1948.
16. King, S. E.: The Syndrome of Chronic Relapsing Pancreatitis—The Frequency of Insular Deficiency (Pancreatic Diabetes) in the Fibrocalcific State, Med. Clinics N. Am., 883, 1949.
17. Knight, W. A.; Muether, R. O.; and Sommer, A. J.: Chronic Recurrent Pancreatitis. Gastroenterology, **12**:34, 1949.
18. Myhre, J.; Nesbitt, S.; and Hurly, J. T.: Response of Serum Amylase and Lipase to Pancreatic Stimulation As a Test of Pancreatic Function. Gastroenterology, **13**:127, 1949.
19. Burke, J. O.; Plummer, K.; and Bradford, S.: Serum Amylase Response to Morphine, Mecholyl and Secretin As a Test of Pancreatic Function. Gastroenterology, **15**:699, 1950.
20. Burke, J. O.: Serum Alkaline Phosphatase in Liver Disease—A Concept of Its Significance. Gastroenterology, **16**:660, December, 1950.

XUM

CORRESPONDENCE

Doctor, Help Prevent Dental Caries.

TO THE EDITOR,
VIRGINIA MEDICAL MONTHLY.
DEAR SIR:

Although the fact is not widely appreciated, dental caries is probably the most prevalent disease in America today, afflicting approximately 97% of our population, usually from early childhood until such time in the later years of life that the last remaining teeth are lost. Thus, while not directly fatal in nature, this disease yearly extracts an enormous toll from our people's health, finances, and general happiness and well-being. For these reasons, it represents an appalling public health problem.

To repair the many millions of unfilled cavities now present in American teeth would be a task far beyond the reach of our present-day dental resources. In fact, less than 25% of the American people receive any regular dental care, except the emergency extraction of "abscessed" teeth and, in some cases, the set of artificial dentures to which such a policy is apt to lead.

The dissatisfaction arising from this situation is lending impetus to programs promoting such socialistic systems as compulsory federal-level health insurance, which dentistry faces along with medicine.

Like all of the other health services, dentistry is turning its attention more and more towards the field of prevention. With this objective in view, the Council on Dental Health last year organized a Conference on Dental Health Education, co-sponsored jointly by the Virginia State Dental Association, the State Department of Health, and the State Department of Education. Dentists, health officers, and educators, 150 strong, met at Virginia Beach, Va., and, during four days of hard work, laid the groundwork, for a far-reaching program of improved dental health education in Virginia, with emphasis on the prevention of dental disease.

The sugar-rich diet is now well-known, beyond any reasonable doubt, to be the major etiologic agent in dental caries. Last year the American people consumed, in various sweets and confections, on an average more than one hundred pounds of sugar per person per year! This figure is amazing to nearly everyone except the dentist who, in his practice, must daily cope with the tragic results of such a national dietary habit.

Sugar, as you well know, contains none of the essential amino acids, none of the essential fatty acids, none of the essential minerals, and no vitamins. Furthermore, its ingestion in considerable amounts will markedly reduce the appetite for those foods which do contain these essential food elements. The physicians are well aware of the nutritional and dietary deficiencies among our population.

With all of the above in mind, the dentists of Virginia are seeking the assistance of the physicians, especially the pediatricians, in promoting the reduced ingestion of sugar-rich foods and drinks, particularly by children. For example, it is most disturbing to us to be informed that many pediatricians habitually reward their young patients for good behavior with, of all things, a lollipop! Nothing yet discovered by man is as efficient in the promotion of dental caries as the hard candies.

The Council on Dental Health will, therefore, be deeply grateful if you can find the space to print this communication in a forthcoming issue of the VIRGINIA MEDICAL MONTHLY. Much good might result.

MILLARD P. DOYLE, *Chairman*
E. BUDGE KENT, *Vice Chairman*
Council of Dental Health
Virginia State Dental Association

April 22, 1953.

Data Available on County Society Activities.

The third bi-annual survey of county medical society activities has been completed by the Council on Medical Service and is available on request. This year the survey covered a broader scope of activity in the field of medical service than previously, and results have been tabulated to show these activities by size of society. County societies may obtain, from the Council, general information on specific medical service programs and lists of societies where such programs already are in operation.

XUM

THE MEDICAL SOCIETY OF VIRGINIA

Committee for American Medical Education Foundation

February 6, 1953

DR. JAMES L. HAMNER, *President*
THE MEDICAL SOCIETY OF VIRGINIA
MANNBORO, VIRGINIA

DEAR SIR:

Recently, I attended the meeting of the American Medical Education Foundation in Chicago. It was a pleasure and honor to represent you and the State of Virginia at this meeting. There was supposed to be a representative of each state present. I did not see the actual breakdown, but there were about 60 persons in attendance. This was a most enthusiastic and inspiring meeting. No doctor could have attended this meeting without catching a vision of the greatness and magnitude of this effort.

As you know, no attempt was made in Virginia to start this drive until April, 1952. Even with such a late start in 1952 the record in Chicago shows that Virginia had 185 contributors last year, who gave a total of $5,424.80. This brought us up to the 17th state in the amount given. If we can contribute $12,000 this year we probably will rate about the 10th state in donations. If we can be rewarded with this good a result for our effort, the name of Virginia will stand out prominently among other states.

As of September, 1952, the Medical College of Virginia had received $36,392 from the National Fund and the University of Virginia had received $35,150. Just make it much more this year.

The American Medical Education Foundation has now gone far enough so that a situation has been created whereby the doctors must make good, or lose face.

It was reiterated that every one of the 79 schools which receives an earmarked donation, receives this donation above and beyond their 1/79th division of monies contributed undesignated for any particular school. In other words, every donation that one gives should if possible go through the A.M.E.F. so as to boost the record of gifts. It was discussed that Johns Hopkins is considering running through the A.M.E.F. fifty or sixty thousand dollars given to them directly. If Johns Hopkins or any other school merely writes to the A.M.E.F. that they received fifty or sixty thousand dollars, the A.M.E.F. cannot claim any credit. The money must go through the A.M.E.F., if only an exchange of checks is made, so that the A.M.E.F. may secure credit.

This is very important because the greatest gifts are expected from corporations and wealthy individuals through the Fund, and some corporations are making promises of $100,000 contingent upon a certain amount being given by the doctors through the Foundation. The American Medical Education Foundation is gifts of doctors only. The American Medical Education Fund is from those who are not M.D.'s. The doctors' solicitations toward their goal are through the medical profession.

Many of the trial and error ways are being gradually ironed out. It seems that every method of campaigning has been tried by someone. One state tried making the Councilors of the state the committee for compaigning for funds, with the Councilors then to have sub-committees, but this did not do so well.

Another state tried making a state committee composed of the presidents of the county societies. This effort was not so well rewarded.

Another state tried a series of letters, using the proven best way—that is, sending three letters, each about 10 days apart. This had some results, but one method stood out best, and that was by word of mouth, or personal contact.

It was reiterated in Chicago that every cent collected goes to the medical schools, and that the A.M.A. is underwriting all overhead as well as giving $500,000 annually to the Foundation. The A.M.A. has made no commitments as to how many years they will do this.

The goal of the Foundation this year is $2,000,000, and if this sum can be reached, the Fund will advance much more rapidly and probably will hit a $10,000,000 total. To reiterate again, it was thought by every speaker in Chicago that the Fund from big givers and corporations will eventually be far more than the Foundation contributions.

In Virginia we have made arrangements through the committee appointed by you to see every doctor in the state. This is rather ambitious, maybe, but the goal will be reached in the next year or two. Any doctor we miss can send his check direct to our state secretary, Bob Howard. In fact, there is no use waiting for a committee man to see a doctor—each doctor can mail his check in to Bob Howard. The sooner this is done, the more quickly our medical

XUM

schools get the money. Every check sent in earmarked for a medical school is forwarded immediately to that medical school.

Many talks were made in Chicago about how we cannot and must not fail our medical schools. The only way seen now to keep out of socialized medicine is to put over the A.M.E.F. There are only three sources of income to save the medical schools from being federalized, and they are—gifts from new organizations, new individuals, and renewals.

In 1951, 1811 contributed to the A.M.E.F. 3700 contributed in 1952. If this number can be doubled in 1953, and it was thought in Chicago that it could be, then we are definitely and rapidly climbing the stairs towards a goal that will mean medicine has been saved, at this point in our lives, from socialization.

I would recommend to every doctor in the State of Virginia to write to the A.M.A. for the pamphlets, "Crisis in Medicine" and "Your Tax Dollars and the A.M.E.F." if they have not read them.

The A.M.A. states that we are graduating over 6,000 new doctors every year and that it should be clear to every doctor that if the medical schools continue to operate without proper finances it will seriously damage the teaching system and ultimately lower the standards of medical practice in the U.S.

The United States enjoys the highest health standards in the world and we cannot permit the creeping paralysis of government control to envelop our schools and ultimately dictate the standards of medical practice.

The medical schools are the foundation of America's health. The medical schools need at least $10,000,000 annually to meet their operating needs. We want these funds to come from private sources.

It now costs $10,000 to train a doctor. Tuition fees raised 165% since 1940 pay only 1/5 of this cost. Funds from other sources must be found. The A.M.E.F. is the answer.

I was greatly impressed in Chicago when I found out that the Woman's Auxiliary is coming to the aid of the doctors in obtaining donations for the Foundation. I was pleased to note on the record that the Woman's Auxiliary in Virginia has contributed to the A.M.E.F. This is a wonderful happening.

In closing, I would like to say that there was in this meeting in Chicago a buoyancy and enthusiasm that will go far towards enabling the medical profession to reach its goal. This Foundation is going forward and I want to see Virginia among the first 10 in the U.S. in their aid to this unusually worthy cause.

Again I thank you for allowing me to represent Virginia at this meeting.

MARCELLUS A. JOHNSON, JR., M.D.

Two Doctors Join AMA Hospital Field Staff.

The recent appointment of Drs. Arthur N. Springall and Joseph J. A. McMullin boosts the field staff of the Council on Medical Education and Hospitals to nine full-time physicians. Each staff member has been assigned a geographic area and will review, on a bi-annual basis, the internship and residency programs in approved hospitals.

This increase in staff will expedite the processing of new applications for approval of internships and residencies and make possible a review of currently approved programs at least once every two years. At present the Council conducts the inspection program relating to the approval of hospitals for internship and residency training—a joint effort of the Specialty Boards, the American College of Physicians and the American College of Surgeons. In addition, the professional staff will assume responsibility for surveys in behalf of the Joint Commission on Accreditation of Hospitals.

Other members of the staff who will be visiting hospitals throughout the country include: Drs. William R. Albus, Joseph R. Anderson, Fernald C. Fitts, Charles C. Hedges, Thure A. Nordlander, Frank W. Ryan and William W. Southard.

XUM

XUM

XUM

Medical Society of Virginia Cancer Committee

Chairman, George Cooper, Jr., M. D.

Albemarle Hotel Building, Charlottesville, Va.

Reprints of this and preceding Bulletins may be obtained from this office

JUNE 1, 1953

Radiation in Advanced Cancer

Steady advances are being made in the diagnosis and treatment of cancer. Physicians are curing about 25 to 30 per cent of cancer patients.

Nevertheless, we still face a situation in which about 70 to 75 per cent of our cancer patients must be handled in advanced and terminal stages of their disease.

In recent years, some very helpful methods of treating advanced cancer have been evolved. New methods should be kept constantly in mind but not to the point where the single most useful (as yet) agent for palliation of advanced cancer, x-ray therapy, is neglected.

X-ray therapy has been used long enough for compilation of statistics showing the percentage figures of response by various cancers. But it is still not possible to predict the response of an individual cancer. In general, the only way to determine the radiosensitivity of any one lesion is to subject it to radiation. It is the rare advanced patient whose tumor has not been proven radioresistant from whom radiation should be withheld.

The object of radiation in advanced cancer is palliation only.

First, it should be used for pain relief. Analgesic and hypnotic drugs should be used in as small amount as possible. It does not help the patient or his family to complicate his illness by an unnecessary drug addiction. X-ray therapy relieves pain (1) by reducing the size of soft tissue tumors. This, in turn, relieves pressure on nerves and permits better vascularization which leads to healing of necrotic ulcers (internal as well as external) and clearing up of infection. (2) It causes recession of bone metastases. Frequently, bone that has been completely destroyed actually regenerates.

Second, it should be used to relieve the mechanical discomfort produced by the presence of bulky tumors. Here again, it is effective by reducing the size of the tumor.

Third, it should be used in the prevention and treatment of pathological fractures. Bone metastasis in itself is usually a very painful affair. When complicated by pathological fracture, pain is intolerable. The patient with advanced cancer should be followed closely for the development of bone pain. Whenever x-ray examination reveals the presence of sufficient bone destruction for fracture to become a possibility, x-ray therapy should be started at once. The patient and his attendants should be warned against use of the part and orthopedic appliances should be used as a protective measure. When fracture has occurred, the x-ray therapist and orthopedist should be consulted immediately. X-ray therapy frequently speeds healing a great deal.

In fact, in patients with known cancer, it is good practice to institute x-ray therapy for pain whether or not metastasis can be demonstrated radiologically. If the pain is due to metastasis, the lesion may be aborted before it has done much damage or caused much suffering. If the pain is not due to metastasis, the failure of response will so indicate. No harm will have been done and the symptoms can be further investigated.

Fourth, x-ray therapy should be used in an attempt to relieve distress other than that caused by bone metastases and nerve pressure. The headaches and neurological disturbances produced by cerebral metastases often yield to radiation. The same is true of the cough, atelectasis, and pneumonitis incident to radiosensitive pulmonary metastases. Proptosis, superior mediastinal block, lymphatic stasis in the extremities due to extensive glandular metastases in the groin or axilla, obstruction in the intestinal or urinary tracts, all are complications which may be alleviated by radiation.

Relief of symptomatalogy and destruction of tumor tissue picks up the general condition. Hemapoiesis, nutrition, and mental outlook improve.

Fifth, in advanced cancers which have proven responsive to one of the newer chemical agents or to alteration of the host's hormonal status, x-ray therapy still plays an important, often the more important role. For example, when a prostatic carcinoma which has been kept under control by means of stilbesterol becomes recalcitrant and resumes activity, often x-ray therapy will bring it back under control. Then when it becomes radioresistant, it may yield again to stilbesterol or castration. By judicious alternation or combination of x-ray therapy with other procedures, some advanced cancers can be controlled successfully for prolonged periods. The cases are few in which some relief cannot be obtained.

XUM

XUM

XUM

MENTAL HEALTH

JOSEPH E. BARRETT, M.D.,
Commissioner, Department of Mental Hygiene and Hospitals

A Summarization of Recent Articles Showing Mental Hospital Problems from a Statistical Viewpoint*

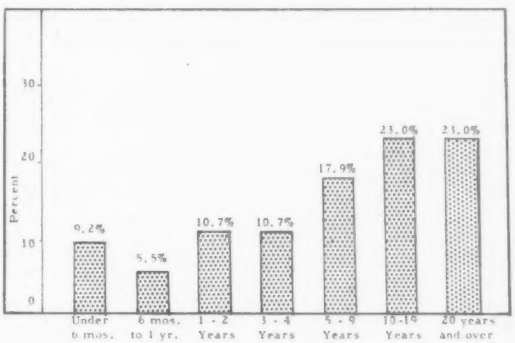
The state mental hospitals in Virginia have advanced in their treatment of the mentally ill in recent years. This is indicated by a change in the rate of discharge of patients. In 1945 the rate per 100 admissions was 55 and in 1952 the rate of discharge was 67.3 per 100 admissions.

The increase in ratio of discharges to admissions over the past years is largely due to new concepts of treatment and as much intensive treatment as possible soon after admission. The ratio of discharges after 6 months hospitalization is far below that of those of less than 6 months hospitalization. Therefore, the longer a patient remains in hospital his chance of discharge decreases at a very fast rate. More and more we realize planning should be developed around concentrated treatment upon the admission of a patient to the hospital. Of course, there is always a risk in releasing patients, but if they are not released when improvement justifies it, they will not have a chance to live as normal a life as they are capable of doing.

In recent articles we have presented a statistical picture of some of the problems of hospital population and certain mental diseases of high frequency—schizophrenia, manic-depressive, senile-arteriosclerotic group and alcoholism.

In summarizing the situation we are confronted with the problem of older persons being admitted to the hospitals, the build-up of older patients by those who have remained for a long period of time and a general increase in hospital population. As of June 30, 1952, 23.0% of the patients in residence had been on record 20 years or longer and 46%, or nearly half the population, had been in residence 10 years or longer. The accompanying chart shows the percentage of distribution of the 10,125 patients in hospital on June 30, 1952, by the length of time on record.

Those diagnosed as schizophrenia comprised 51.6% of those in hospital 20 years or longer, and manic-depressive psychosis 25.8%. All other diseases were 22.8%. From this it behooves a concentration on treatment of schizophrenia and manic-depressive to prevent such a large percentage remaining such a long period of time. Recognition of these mental disorders in the early stages followed by treatment before they reach the chronic stage, would also prevent many from becoming old in the mental hospitals.



Percentage distribution of length of time on books of patients resident in hospitals as of June 30, 1952.

The admission of older people—those diagnosed as senile or psychosis with arteriosclerosis—is of much concern to the state hospital authorities. First admissions in this group have increased from 19.2% in 1940 to 32.8% in 1952. This rapid increase in these admissions has placed a burden on present facilities to care for them. It is evident that definite plans must be made for this group. With the expectancy of life increasing, an increase in the admission of this group may also be expected. Even though their hospitalization is usually of a short duration, which usually terminates in death after an average of 2½ years hospitalization, they must have treatment and care.

Another specific problem is that of the alcoholics. Even though the discharge rate to admissions is relatively one for one, which indicates a short treatment period, they create a time consuming problem for the physicians and staff.

It is not wise to have the alcoholics hospitalized with the mentally ill patients. Though many may have emotional problems that need psychiatric treatment, it is believed that more success could be attained with separate facilities for these patients with a concentration on the type of treatment necessary

*Article by Edna M. Lantz, Statistician, Department of Mental Hygiene and Hospitals.

XUM

for the alcoholic. The first admissions of alcoholics have ranged from a high of 23.0% to a low of 7.0% of all first admissions. The readmission rate is slightly higher ranging from 24.7% to 12.4%. This means that 500 to 700 alcoholics are admitted to the hospitals each year.

The overcrowding in the hospitals is also a hindrance to the best results from treatment. Among the problems in overcrowded conditions, is the necessity in many cases of placing newly admitted patients among those who have been hospitalized for a period of time; the older age patients with younger patients and the chronic with acutely ill patients. At the present time the overcrowding is 19% of the rated capacity of the four state hospitals. With the opening of new buildings, the decrease in the past year in overcrowding was 3%. New buildings have added 8% more space, but the increase in population held the overcrowding to the 3% reduction. Plans have been made for moving two of the hospitals to new locations. The reduction in overcrowding, however, will be slow because of the time necessary in construction of new buildings. Also, there will not be much change in one of the hospitals because old condemned buildings will be razed as soon as vacated.

Mental illness is a number one health problem. Therefore, our efforts should be concentrated on reducing this problem with improved methods of care and treatment because if a person becomes mentally ill he should not be forgotten. Some of the ways this can be done are:

1—Early recognition of mental and emotional disorders to be followed by treatment in the early stages which will prevent many chronic cases.

2—Special facilities for the care of patients admitted with the diagnosis of senility and arteriosclerosis. These constitute about a third of the first admissions at the present time and an increase can be expected in future years.

3—Immediate intensive treatment of psychotic patients so that their chance of return to their homes and communities may be increased. This requires qualified and trained personnel and uncrowded facilities.

4—Separate institutions for the treatment of alcoholics so that the treatment best suited can be administered without conflicting with the treatment of mentally ill patients.

5—A long range, well formulated, planning program is necessary and the plans must be carried out if we hope to meet completely the problem of mental illness to reach a goal of good mental health. A beginning has been made, but it will take the cooperation of the public, the government and hospital authorities to succeed.

AMA Offers Two New Exhibits.

Two new exhibits will be available for showing at state medical society meetings this fall, the Bureau of Exhibits reports. One exhibit—"Accidental Poisoning in Children"—is based on authentic fatal accident cases, while the other—"A Medical Service Program for your Community"—covers various activities of medical societies and voluntary and public health agencies.

The exhibit on accidental poisonings, from the Committee on Pesticides, emphasizes points of danger in the home, yard and selected farm locations. When staffed with trained personnel, this makes an effective showing at public gatherings, state and county fairs, food and home shows. Subjects included in the exhibit developed by the Council on Medical Service range from care of the chronically ill to hospital construction, physician placement, and rehabilitation.

Both exhibits require space 10 feet long and six feet deep—or, if shown in extended fashion, 20 feet long and three feet deep. Requests for bookings may be made to the Bureau of Exhibits after June 15.

XUM

PUBLIC HEALTH

MACK I. SHANHOLTZ, M.D.
State Health Commissioner of Virginia

Gamma Globulin in Poliomyelitis

Gamma globulin to be used as a measure to temporarily protect contacts to cases of poliomyelitis against development of paralysis, is being distributed by the Office of Defense Mobilization to State and Territorial Health Departments on the basis of their past experience with the disease. The State or Territorial Health Commissioner has the full responsibility for the distribution of the gamma globulin allocated to him.

Gamma globulin is a derivative of whole blood obtained by a process of separation and concentration from batches of pooled blood obtained from normal adults. The immune substances or antibodies are present in the globulin fraction of the blood. Since the blood is the mixture of many adult bloods and a majority of adults are immune to one or more of the three strains of poliomyelitis, the immune substances or antibodies against all three virus types are present. The use of gamma globulin may confer a temporary passive immunity of four to six weeks' duration against the paralysis of poliomyelitis if it is administered to contacts shortly after exposure to the disease. Gamma globulin does not have any value in the treatment of poliomyelitis. It should be emphasized that while the reports on the use of gamma globulin in protecting against the paralysis of poliomyelitis have been encouraging, the immunity conferred is only temporary and is not 100 per cent effective.

The supply of gamma globulin is limited. The greater part of the total supply will be available for the prophylaxis of poliomyelitis. The allocation of immune globulin for prophylaxis of measles and infectious hepatitis will be continued on a stated basis and will be separate from that for poliomyelitis.

The method of distribution in Virginia has been approved by the Poliomyelitis Committee of The Medical Society of Virginia and will be made to the City and County Health Departments on the basis of population of children between the ages of six months to fifteen years. Gamma globulin will be used for this age group who have had household contact with a patient whose diagnosis has been confirmed in one of the Centers for treatment of poliomyelitis. By household contact is meant people living in the same home and who share the intimacies of bath, rooms, and table. The physician will make his request for gamma globulin to the Director of Public Health within the area of residence of the contact. Forms are provided by the State Health Department for making these requests. In addition to the age group six months to fifteen years, gamma globulin will be supplied for prophylaxis in household exposure of pregnant women. It is indicated that the mortality rate (not the attack rate) is higher during the late months of pregnancy and early postpartum period. The approximate dosage recommended in all cases is 0.14cc. per pound of body weight up to 10cc.

There are more than one million children in Virginia and the supply of gamma globulin is an amount that may be used on approximately 3,000 contacts. In Virginia 76 per cent of the cases of poliomyelitis have been in the age group not more than 15 years of age. Distribution for use in the age group selected will, therefore, be effective in preventing the greatest number of cases.

The amount of gamma globulin necessary to protect the average child is produced from a pint of blood. The amount of available blood plus the facilities for processing the blood are factors which cause the supply to be limited. Gamma globulin cannot be bought and it is stressed that regulations must be followed. Gamma globulin within current dates for use may be obtained only through health departments. Physicians are encouraged to use as much as but not more than is needed to treat a particular contact. There is no charge made for gamma globulin but the physicians may make their regular charge for routine inoculations.

The physicians also agree that they will furnish follow-up information regarding the protection afforded by the use of gamma globulin. This is particularly important in evaluating the over-all effectiveness of this agent in protecting against the paralysis of poliomyelitis.

XUM

MONTHLY REPORT OF THE BUREAU OF COMMUNICABLE DISEASE CONTROL

	April 1953	April 1952	Jan.-April 1953	Jan.-April 1952
Brucellosis	1	3	16	7
Diarrhea & Dysentery	8	77	341	527
Diphtheria	1	9	45	36
Hepatitis	185	34	753	246
Measles	842	3442	2321	9557
Meningitis (Meningococcic)	16	29	103	82
Poliomyelitis	3	0	10	11
Rocky Mt. Spotted Fever	2	1	2	3
Scarlet Fever	125	117	466	381
Tularemia	0	0	14	22
Typhoid & Paratyphoid	4	4	16	18
Rabies in Animals	41	54	193	223

How to Get a Doctor—Booklet Available Soon.

A new pamphlet—"A Doctor for your Community"—will be published some time in June by the American Medical Association. This booklet, directed toward communities seeking a physician, describes briefly the problems involved in obtaining a doctor, the things a community can do to attract and keep a doctor, and examples of what has been done elsewhere. A joint project of the Council on Medical Service, Council on Rural Health and Department of Public Relations, the booklet will be available to state medical societies for distribution to communities listed with their placement services.

In addition, the Council on Medical Service has compiled information from numerous state placement services in a reprint which will be especially useful to state societies interested in expanding their activities in this field.

New Platters—AMA Contributions to Better Health.

Common health problems and how the American Medical Association has helped to solve them form the basis of a new series of radio transcriptions to be released May 15. The 13-program series—"Yours for Health"—shows how the work of various AMA councils and committees has contributed to better health for the American people. Subjects included in the series prepared by the Bureau of Health Education: (1) How Do We Know? Facts and Statistics, (2) Food and Nutrition, (3) The Part Played by Drugs, (4) Impaired Hearing and Hearing Aids, (5) Training Good Doctors, (6) You and Your Hospital, (7) It's the Law, (8) Defense Against Poisons, (9) Safe Cosmetics, (10) Meeting Medical Costs, (11) Health and the Aged, (12) Driving Out the Quacks, and (13) Mental Health.

Add to Lists of Library and Films Cleared for TV.

Supplementary lists of films cleared for television and films available through the AMA's motion picture library now may be obtained from the Committee on Medical Motion Pictures. One supplement lists 38 health education films cleared for TV since publication of the original list in 1951. The other includes 12 motion pictures added to the library since the December, 1952, catalog was published.

PR Tip of the Month.

In unity is strength. If medicine's public relations program is to be effective, we must not permit internal conflicts to divert our interest or attention from the public service objectives to which we have dedicated ourselves. Let's build PR bridges—not batter them down!—*PR Doctor*

XUM

WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF VIRGINIA

President—
MRS. THOMAS N. HUNNICUTT, JR., Newport News
President-Elect—MRS. K. W. HOWARD, Portsmouth
Treasurer—MRS. WM. C. BARR, Richmond
Recording Secretary—MRS. LEE S. LIGGAN, Irvington
Corresponding Secretary—
MRS. F. A. CARMINES, Newport News
Publication Chairman—
MRS. ROBERT H. DETWILER, Arlington

News from Auxiliaries.

SOUTHWESTERN VIRGINIA

The Woman's Auxiliary to the Southwestern Virginia Medical Society met at the Lincoln Hotel, Marion, April 16, with thirty members present. The new president, Mrs. James P. King, Radford, presided. Following the reading of the Auxiliary Creed, Mrs. Willis Sprinkle, president of the Smyth County Auxiliary, welcomed the visitors with Mrs. C. G. Fox, Jr., Pulaski, giving the response.

The usual business was transacted and reports of committees given. Mrs. King explained the goal—"Every Auxiliary a Contributor"—of the American Medical Education Foundation. Contributions were made to this fund and to the Leigh-Hodges-Wright fund. Mrs. Kalford W. Howard, President-elect, Woman's Auxiliary to The Medical Society of Virginia gave an interesting and inspiring address on "Organized Loyalty".

Following the meeting members of the auxiliary were guests of the Smyth County Auxiliary on a tour of the Southwestern State Hospital and a tea before joining the physicians of the Society for a social hour and banquet at the Lincoln Hotel.

ADA LEE COATES, *Secretary*
(MRS. JOSEPH COATES)

ARLINGTON

On the Fashion Show sponsored by the Auxiliary on March 10, a profit of $631.05 was realized. It is planned to add this to the $700 given the Arlington Hospital last year to go toward the purchase of a Doctor's "Call Board" for the Hospital.

Arlington physicians were remembered on National Doctor's Day when members of the Auxiliary presented each doctor with a red carnation boutonniere. Mrs. Sigmund Newman, chairman of the project, entertained members of the Auxiliary with a coffee-fest prior to distributing the flowers.

RICHMOND

For the second part of our "Doctor's Day" observance, we gave sample drugs to the Retreat for the Sick and Sheltering Arms Hospitals on "Doctor's Day", March the 30th.

Mrs. Russell Snead and her committee did a wonderful job collecting and separating the sample drugs. It was estimated that we gave approximately $5,000.00 worth to Sheltering Arms Hospital. The amount we gave to Retreat for the Sick was not estimated.

Mrs. Maynard Emlaw, our president, arranged for Polly Daffron to interview Dr. T. W. Murrell, Sr. on her radio program on "Doctor's Day". He spoke on "Advances in the Practice of Medicine".

All of the members of the Richmond Auxiliary have been working for the past two months on our annual "Benefit Tea", which was held at the home of Dr. and Mrs. W. Taliaferro Thompson, Jr., in Windsor Farms, on Friday, May 1st, from three to five o'clock. The tea guests were invited also to visit the lovely garden of Mr. and Mrs. F. H. Reaves, on Massie Road in Windsor Farms.

Mrs. W. A. Dashiell was General Chairman; Mrs. William Cox, Ticket Chairman; Mrs. L. W. Hulley, Jr., Arrangements Chairman; Mrs. Hunter Jackson, Hostess Chairman; Mrs. T. W. Murrell, Jr., Flowers; Mrs. Wyndham Blanton, Jr., Tea Table; Mrs. William Spencer, Baked Goods Chairman; Mrs. Custis L. Coleman, Refreshments Chairman; Mrs. W. P. Morrissette, Sandwich Chairman; Mrs. R. B. Lawrence, Punch Chairman; Mrs. George Ritchie, Cookie Chairman.

Members of the senior classes of the nursing schools of the Medical College of Virginia, Johnston-Willis, Stuart Circle, St. Luke's, St. Elizabeth's, and Grace Hospitals were invited to attend the tea as special guests of the Auxiliary. The exact amount cleared on the tea will be reported later.

We furnished 28 volunteers to man one of the Richmond Chapter, American Cancer Society Booths in a local department store, April the 20th through the 25th.

JANET F. COLEMAN (MRS. CUSTIS L.)
President-elect

XUM

NORTHAMPTON-ACCOMAC

The Auxiliary held its annual spring meeting at the home of Mrs. Joseph E. Gladstone at Exmore on April 14th, with fourteen members present. The meeting was opened with The Lord's Prayer by the vice-president, Mrs. E. E. Mihalyka, in the absence of the president, Mrs. John R. Hamilton. Minutes of the January meeting were read by the secretary, Mrs. H. L. Denoon, Jr., and Mrs. John Rogers Mapp, treasurer, gave her report. These were accepted. Mrs. Mihalyka gave a short history of the units of the auxiliary, and their functions.

A talk on the magazine "Today's Health" was given by Mrs. Holland Trower. This magazine, which is the publication of the American Medical Association, gives non-technical authoritative, easy to read articles published monthly by the A.M.A., which help to set the nation's health standards.

Mrs. J. Fred Edmonds gave a talk on the Bulletin of The Woman's Auxiliary which gives news of the workings of the Auxiliaries to the A.M.A. Reports of the National and State Conventions, Auxiliaries' activities, and anounced the Convention of the American Medical Association and The Woman's Auxiliaries to be held in New York City on June 1st to 5th.

Mrs. John R. Mapp then gave a moving and dramatic history of the operation on the pioneer woman, Jane Todd Crawford, of Rockbridge County, in the year 1800, for the removal of a 15 lb. tumor, on Christmas Day, by Dr. Ephraim McDowell. The townspeople were violently opposed to the operation, and gathered in protest and were preparing to hang the doctor should the patient die. The operation was very successful, and was the most important in the history of surgery, and Mrs. Crawford lived to be 79 years old.

The Auxiliary voted to give twenty dollars towards the Cancer Control fund—ten dollars for Accomac County and ten dollars for Northampton.

The meeting adjourned, and the auxiliary will be the guests of Dr. and Mrs. John R. Hamilton in July at their farm "Endview". This meeting will be a joint meeting of the Doctors and their wives, and the State president of The Woman's Auxiliary will be invited to attend. This meeting will also honor "Doctor's Day".

After the business meeting, the members enjoyed a delightful tea and social hour.

CATHERINE R. TROWER (MRS. HOLLAND)
Chairman, Press and Publicity

BOOKS

From The Workshop of Discoveries. By OTTO LOEWI, Research Professor of Pharmacology, New York University College of Medicine. Porter Lectures, Series 19. University of Kansas Press, Lawrence, 1953. 62 pages. Cloth. Price $2.00.

Operative Gynecology. By RICHARD W. Te LINDE, Professor of Gynecology, Johns Hopkins University and Chief Gynecologist, Johns Hopkins Hospital. Second Edition. J. B. Lippincott Company, Philadelphia. 1953. xxiv-902 pages. 409 figures and 7 color plates. Cloth. Price $20.00.

The Conception of Disease. Its History, Its Versions and Its Nature. By WALTER RIESE, M.D., Richmond, Virginia. Philosophical Library, New York, 1952. 120 pages. Cloth. Price $3.75.

This book is born of an intimate knowledge of medical history and of philosophy, acquired by the author during his many years of research and teaching activity in neurology and the history of medicine. Although each period of civilization formed its own particular conception of disease based upon its prevailing philosophy, the preceding conceptions never completely passed out of existence. They were either integrated into the newer conception or continue to exist side by side with it. Thus the growth of our present day conceptions of disease started in Greek-Roman culture and were influenced by all major developments in civilization. "The modern physician trying to make a diagnosis proceeds in the same way and uses the same intellectual avenues as his Roman forerunner." What has been added are mainly perfections in techniques and clarifications of certain issues. The rise of anatomy in the Renaissance gave full significance to regional aspects, the rise of pathology in the 18th century emphasized the lesions, and bacteriology finally widened the etiological aspects. Not only the historical-philosophical origin of the various conceptions of disease are discussed

by the author, but also their justifications, uses, and limitations. More than 100 footnotes and a carefully prepared index increase the value of this book, which contains numerous provocative thoughts for every physician with some philosophical or historical interests.

E.F.

Textbook of Surgery. Edited by H. F. MOSELEY, M.A., D.M., M.Ch. (Oxon), F.A.C.S., F.R.C.S. (Eng.), F.R.C.S. (C), Assistant Professor of Surgery, McGill University; Associate Surgeon, Royal Victoria Hospital, Montreal, Canada. With Foreword by G. Gavin Miller, M.D., C.M., M.Sc. F.R.C.S. (C), F.A.C.S., Chairman of the Surgical Department, McGill University; Surgeon-in-Chief, Royal Victoria Hospital. St. Louis, The C. V. Mosby Company. 1952. xxi-896 pages. With 460 Text Illustrations and 46 Color Plates. Cloth. Price $15.00.

This book represents an integration of materials presented visually by its many excellent color plates and diagrams, and descriptively by its brevity and precision of written word. It is apparently organized to assist the medical student in his study of surgery and while he is interning. Hence, it does not serve as a technical reference for the skilled surgeon. The authors have provided valuable correlations of the study of surgery with anatomy, physiology, and pathology and "nudges" the student to desire more detailed information about the subjects discussed.

S.E.F.

The Low Fat Diet Cook Book, By DOROTHY MYERS HILDRETH and EUGENE A. HILDRETH, M.D. Introduction by Francis C. Wood, M.D. Medical Research Press, New York. 1952. xi-148 pages. Cloth. Price $2.95.

This specialized cook book was written by a dietitain and a doctor especially for the patient on a low fat diet. It should prove helpful to all such patients, if the cost of meals is not a prohibitive factor, and it will be of interest to dietitians and nutritionists working with out-patients.

A basic low fat diet containing 25-35 grams fat is outlined. Easy to follow directions are given on how to adjust the fat to a lower (or higher) level if the doctor so ordered. How to decrease the cholesterol content of the diet is also discussed as well as valuable suggestions for increasing or decreasing total daily caloric intake while still keeping the fat at a set amount.

The outstanding feature of the book is the variety it offers to a low fat diet through its 200 recipes. These, on the whole, are excellent, as are the menus, and give so many interesting food combinations. Herbs, wines and spices have been used occasionally, changing ordinary types of dishes into ones with special appetite appeal. For patients who are not allowed mineral oil salad dressings, two other recipes have been added which would be tasty substitutes. One suggestion from the reviewer is that lay persons who are to use this book be told to measure butter (when allowed) in standard teaspoons rather than to guess at a "standard pat".

It is gratifying in this day of fad diets to find the authors emphasizing the use of necessary foods each day. Their menus illustrate this by meeting the National Research Council recommended allowances for nutrients.

E.A.L. AND E.M.B.

The Literature on Streptomycin, 1944-1952. By SELMAN A. WAKSMAN, Institute of Microbiology, Rutgers University, Rutgers University Press, New Brunswick, New Jersey. 1952. xii-553 pages. Cloth. Price $5.00.

Here is a bibliography of interest and value to the investigator as well as to the clinician. The importance of the subject treated is evidenced by the fact that between the appearance of the first edition in 1948, and this revised edition in 1952, the number of references dealing with Streptomycin has increased from 1200 to nearly 6000! The 5500 references included in this work are listed in chronological order.

Various aspects and uses of the drug are mentioned in the literature listed, such as methods of isolation and purification, pharmacological, chemotherapeutic aspects, and many others including newer uses that have been developed.

No more new editions of this bibliography are planned, but annual supplements will be issued. This revised edition is a listing as complete as possible, gathered from the resources of Rutgers University and the Medical Department of Merck & Co.

Subject and author approaches are provided. Improvements are needed in the indexes as some joint author have been omitted, and some items are not approached through either index.

Due to the inclusion of background articles, and of articles that deal with other antibiotics as well, this bibliography may be used in a limited way for antibiotic literature. This work should be welcomed as a contribution toward bibliographic organization.

S.M.

XUM

EDITORIAL

The Physician's Responsibility in the Early Diagnosis And Treatment of Cancer of the Lung

THE frequency of cancer of the lung has increased until now it comprises 10 per cent of all cancers and in many institutions represents the commonest malignancy seen in the male sex.

The medical profession has failed to achieve a high percentage of success in the early recognition of cancer of the lung. It is necessary to stress the tragic delay of eight to twelve months existing between the onset of frank symptoms and definitive therapy. The physician and specialist are responsible for considerably more than 50 per cent of this delay. The patient himself is less culpable than the medical profession.

Until some better means of therapy is available surgery offers the only hope of cure for patients with pulmonary cancer. What is the present situation as regards the surgical treatment of carcinoma of the lung? At least 30 per cent of patients are hopelessly inoperable when first seen. An additional 30 per cent are hopefully explored by an optimistic surgeon but the lesions cannot be resected. In only 40 per cent of the total number of patients seen can the cancer be resected, and of these lesions only half or 20 per cent can be considered localized lesions with a good prospect of cure. The five year survival rate of the entire group is under 10 per cent. The five year survival rate of the resected group is between 15 and 20 per cent. The five year survival rate of the resected group with localized lesions, however, will exceed 40 per cent.

Early diagnosis offers the best means of improving the present results of surgical treatment. To a limited extent the layman can be educated to appreciate the early symptoms of cancer of the lung. The greatest room for improvement, however, lies within the medical profession. The age of specialization has not yet corrected our deficiencies. One surgeon reports a longer lag period now than five years ago and a two to three months longer delay for private than for ward patients. This discouraging fact has probably resulted from attempts by the physician or specialist to obtain positive proof of cancer before submitting a cancer suspect to surgery. Exploratory thoracotomy is the most accurate means of making a diagnosis and far safer than waiting until proof can otherwise be obtained and the cancer is hopelessly advanced.

Although the peak incidence of cancer of the lung occurs in the sixth and seventh decades, it is quite common in the fifth decade of life and by no means rare in the fourth decade. Thus the young individual becomes a suspect also. Although the susceptibility of the male sex exceeds that of the female by fifteen to one, this percentage can never be used as a basis for excluding carcinoma of the lung in the female.

Until a suitable chemical test can be developed, the greatest hope for early diagnosis in cancer of the lung lies in mass survey studies by roentgenology. This is a relatively cheap and effective means of detecting cancer suspects. One in every ten thousand so studied has harbored a silent lung cancer. Where surgical therapy was sought without delay almost 100 per cent of these lesions have proved resectable and approximately 70 per cent have been found localized with good prospects of cure at the time of resection. Too often, however, such lesions have been shrugged off or the patient told to return in six weeks for another roentgenogram. Such a policy has no justification. If cancer is suspected on the original film, even though histologic proof by bronchoscopy or bronchial secretions is lacking, exploration is indicated.

In most early silent cancers of the lung discovered by roentgenography, the so-called

XUM

"coin" lesion is observed. Such a lesion closely resembles a tuberculoma, a chondroma or hamartoma, a fluid containing cyst, or a metastatic lesion. In almost all such cases bronchoscopy will be negative. With expert help, with careful collection of bronchial secretions, and with industrious search a positive diagnosis can be made from cancer cells in the bronchial secretions in 50 per cent of these early lesions. Such facilities are not often available. At least three specimens of bronchial washings or sputum must be submitted to the pathologist. It is important to emphasize that negative results have no value. The negative patients remain cancer suspects and exploratory thoracotomy must be utilized for diagnosis. Attempted biopsy by needle aspiration is definitely contraindicated. A negative result means nothing; a positive result means a very real danger of implantation of cancer cells along the needle track or in the chest wall, or possible embolization through the blood stream. Needle biopsy should be reserved for obviously inoperable cases in which a histologic diagnosis is necessary to guide palliative therapy.

At thoracotomy the surgeon can make the diagnosis by local or segmental resection with a minimal sacrifice of lung tissue in the case of a benign lesion and with the institution of appropriate resection for the malignant lesion.

Repetitious x-ray studies to determine whether a lesion enlarges have no justification. If x-ray study indicates enlargement of the lesion after six weeks or after six months, much valuable time has been lost. If the lesion fails to enlarge on the roentgenogram no important additional information has been gained, since it has been clearly shown that some pulmonary cancers remain apparently inactive by roentgenographic evaluation for months or even years. The decision to operate or not to operate should be made on the basis of the original investigation.

From time to time asymptomatic patients are said to refuse surgery. Under such circumstances we believe that it is the professional duty and moral obligation of the first consulting physician after his initial diagnostic studies to apprize the patient of the possibility of cancer of the lung and to urge proper therapy. Too often the remorseful patient is later heard to say, "But I was only told I had a tumor or a shadow in the lung," or, "I was told to come back in six weeks but I felt fine and didn't return."

If uncertainty still exists after all appropriate diagnostic studies have been utilized including, if necessary bronchoscopy, cystology, bacteriology and special roentgenography with laminography or bronchography, exploratory thoracotomy should not be postponed.

Cancer of the lung is a great mimic and masquerades under many guises.

Cancer of the lung frequently eludes the physician under the guise of pulmonary infection. This is usually due to complete or partial obstruction by tumor of the bronchus to a segment or lobe. Partial or complete regression of pneumonitis may occur under antibiotic therapy and cause the physician to overlook the underlying cause of the pulmonary infection. Or bronchiectasis demonstrable by lipiodol studies may be accepted as the primary disease. "Virus" pneumonia is carcinoma of the lung until proved otherwise. Chronic unresolved pneumonitis does exist but this cannot be accepted as the primary etiology until carcinoma of the lung has been ruled out. The failure of any undiagnosed pulmonary infiltrative process to resolve after three weeks of antibiotic therapy is sufficient indication for bronchoscopy and other diagnostic studies, leading, if necessary, to exploratory thoracotomy.

The underlying cause for an empyema should always be sought. Empyema following lobar pneumonia is extremely rare today. Empyema may result from a lung ab-

XUM

scess, bronchiectasis, from the rupture of a tuberculous focus, or from infection in a lung distal to an obstructed bronchus. Empyema resulting from pneumonitis secondary to obstruction by carcinoma is a not infrequent occurrence. Bronchoscopy should be advised if the slightest uncertainty exists regarding the cause of the empyema. Persistence of densities in the lung field after adequate treatment of the empyema should arouse immediate suspicion.

Carcinoma of the lung may necrose centrally and simulate lung abscess. Usually the wall of a necrosing tumor will appear thicker than that of a pyogenic abscess and the inner layer of the wall irregular and somewhat ragged. However, this differentiation is not universally reliable.

Carcinoma of the lung often mimics tuberculosis. It is often impossible to differentiate a small peripheral carcinoma from a tuberculoma. Other confusing situations involving cavitation are encountered. A pyogenic abscess cavity distal to a neoplastic obstruction of a bronchus may closely resemble a tuberculous cavity. A decrease in the size of the cavity on antibiotic therapy may lead to further confusion. The finding of a negative sputum in a patient with an open cavity should excite further inquiry.

The coincidental occurrence of carcinoma and tuberculosis all too often leads to a fatal delay. Active tuberculosis is being seen more frequently in the older age group. Carcinoma may cause reactivation of a quiescent lesion or erosion into a tuberculous focus. Thus one must remain alert to the possibility of a cancer of the lung even in the presence of a positive sputum for tuberculosis.

Arthralgia may present as the initial symptom of cancer of the lung. This often leads to a presumptive diagnosis of rheumatoid or degenerative arthritis with a resulting lapse of many months before a chest film reveals the true cause of the arthralgia. Clubbing may or may not be observed in conjunction with the arthralgia.

The wheeze resulting from an intrabronchial mass partially obstructing a major bronchus has too often been labeled a manifestation of bronchial asthma. Careful auscultation will permit unilateral localization and serve to differentiate the two conditions.

Onset of persistent cough or change in the character of a previous "cigarette" cough, even in the absence of any other symptoms, should prompt careful investigation.

If cancer of the lung is to be diagnosed early, an extremely high index of suspicion must be maintained by the physician.

L.H.B.

First Western Hemisphere Conference of the World Medical Association

DURING the week of April 21-25, Richmond earned for itself an enviable place on the medical map of the Western Hemisphere. It was the *locale* of the First Western Hemisphere Conference of the World Medical Association. We started to say "host" but that is not strictly correct for the A. H. Robins Company, Inc., furnished a quarter of a million dollars to provide for expenses of the delegates and their entertainment. Their excuse, if excuse be necessary, was that they were celebrating their own seventy-fifth anniversary and their moving into a fine new plant.

"Seventy-five years" was the theme of the meeting. Each State in the Union was

represented by a doctor who was seventy-five years old, who was nominated by the Governor of his State upon the invitation of Governor Battle. They came as guests of the Conference and added much to the general interest of the meeting. The papers and panel discussions all treated of the advances in medicine in the past seventy-five years. These papers will be gathered into a volume entitled "Seventy-Five Years of Medical Progress, 1878-1953." There was no age test for the representatives of the medical societies of Canada and the Latin American Republics, but they also had their expenses paid. Much entertainment befitting distinguished guests was provided. There were sightseeing trips, breakfast meetings, luncheon meetings, dinner meetings, a banquet, and an all day trip to Williamsburg.

Our professional brothers to the South are great sticklers for rank and official recognition. Most of the foreign delegates were presidents or high officials of national or international societies in their own countries. Secretary-General of the World Medical Association, Louis H. Bauer, M.D., presided over the plenary sessions and the "Top Brass" of the American Medical Association were out in full force. The talking talent—lectures, panel discussions, etc.—was supplied by professors in universities across the country from the Atlantic to the Pacific. Governor Battle graciously and efficiently supplied the official glamour.

Space does not permit a detailed notice of reports on medical education, social security, industrial medicine, the exchange of scientific information, and health problems, nor of the many panel discussions of important new work in the 19 areas of specialization. Our visitors seemed well pleased with both the scientific and cultural aspects of the Conference.

Southern Pediatric Seminar

THE Southern Pediatric Seminar will hold its 33rd annual session this summer in Saluda, North Carolina. Two weeks (July 20 through August 1) will be devoted to pediatrics and one week (August 3 through 8) will be devoted to obstetrics.

This is an institution of which doctors in the south have a right to be proud. It was founded by a southern doctor, it is owned and operated by southern doctors, and its faculty members consist of outstanding southern physicians. It has been deemed by many the best postgraduate course in pediatrics and obstetrics available in the country today.

The course consists of lectures, clinics, demonstrations, clinical pathological conference. The members of the faculty are equally divided between physicians in teaching positions and physicians in active practice. Ample opportunity is given for discussions in small groups and for the answering of questions. Every effort is made to give the general practitioner the material and information which he needs in his every day practice.

The course is fully accredited by the American Academy of General Practice.

One great feature of the Seminar is that it is held in the cooling atmosphere of the mountains of North Carolina and many physicians make of the occasion a vacation as well as a time for learning, taking their wives and children with them. Provision is made for the housing of families.

Any general practitioner who is anxious to catch up on what is new in the fields of pediatrics or obstetrics is urged to write for further information to Dr. D. L. Smith, Registrar, Saluda, North Carolina.

XUM

SOCIETIES

The Southwestern Virginia Medical Society

Held their Spring meeting at the Lincoln Hotel, Marion, on April 16, under the presidency of Dr. Frank A. Farmer of Roanoke. The following Scientific Program was presented:

1. "The Present Status of NPH Insulin"—Dr. Bennett Y. Cowan, Bristol
2. "The Management of Cardio-Spasm"—Dr. Marcellus Johnson, III, Roanoke
3. Symposium—*The Management of Pain*—Speakers from the Department of Neurology and Psychiatry of the University of Virginia
   "Personality Factors"—Dr. David C. Wilson
   "The Relations to The Nervous System"—Dr. Cary G. Suter
   "The Use of Drugs in The Control of Pain"—Dr. Edward V. Jones, Jr.

Following the Scientific program, a short business session was held. The Society stood in a body for a minute of silence in honor of the memory of Dr. Linwood Keyser and Dr. E. L. Lawrence of Roanoke. Dr. Andrew Giesen gave a short report on Selective Service and Grievance Committee and Dr. J. T. Showalter reported on the Public Relations Committee. A motion was made by Dr. H. M. Hayter of Abingdon, in expression of professional respect of the Society of Dr. T. K. McKee of Saltville, who has concluded 54 years of service to the medical profession and to his community. It was moved and seconded that his name be placed before The Medical Society of Virginia for the honor of the practitioner of the year. The membership committee presented the names of twelve physicians who were elected to membership.

The meeting was adjourned until 7:00 P.M., at which time Dr. Richard L. Masland, Department of Psychiatry and Neurology, Bowman-Gray School of Medicine, Winston-Salem, North Carolina, spoke on "Minor Convulsive Seizures Resembling Functional or Visceral Diseases."

JAMES L. CHITWOOD
Secretary-Treasurer

Williamsburg-James City County Medical Society.

At the September, November and February meetings of the Society, several doctors were admitted to membership. On February 20, members and their wives or guests met at the home of Dr. and Mrs. Joseph E. Barrett in Williamsburg for a cocktail hour, followed by dinner at Eastern State Hospital. At this meeting, the scientific program was given by Dr. W. L. Southworth on civil defense, and officers were elected for 1953.

The Society met in the Williamsburg Lodge April 18, at 7:00 P.M. for dinner followed by a business meeting.

The newly elected officers were installed as follows: Dr. Hugh G. Stokes, Williamsburg, President; Dr. J. M. Henderson, Williamsburg, Vice-President; and Dr. E. B. Kilby, Toano, Secretary-Treasurer. The new president appointed eight committees as follows:

Membership—Dr. G. L. Jones, chairman
Program—Dr. B. T. Painter, Chairman
Public Relations—Dr. Linwood Farley, Chairman
Selective Service—Dr. G. L. Jones, Chairman
Grievance—Dr. J. R. Tucker, Chairman
Fluoridation of Water—Dr. H. M. Stryker, Chairman
Nominating—Dr. Frances E. Wood, Chairman
Committee of Study Constitution of the Society—Dr. Joseph E. Barrett, Chairman

The president expressed the hope that the public will make known to the society any complaint they may have against a physician. This complaint will be studied by the grievance committee.

The society voted to have nine meetings each year to be held at 6:00 P.M. second Wednesday of each month except June, July and August. The meeting was adjourned to meet at 6:00 P.M. Wednesday May 13th.

Wise County Medical Society.

At Hotel Norton, on the evening of April 8, thirty-five doctors enjoyed a steak dinner and an outstanding lecture by Dr. George M. Cooper, Professor of Roentgenology at the University Hospital, Charlottesville. This was illustrated by pictures on diagnosis and treatment of cancer with emphasis on x-ray limitation and diagnosis. He emphasized the importance of careful and complete histories and physical diagnoses. Dr. John D. Winebrenner, Area Medical Administrator, U. M. W. A. Welfare and Retirement Fund, spoke briefly. He will present our program at the next meeting on June 10th.

The proposed cancer diagnostic clinic was indorsed. The following committee was selected to organize it under the direction of Dr. George M. Cooper: Drs. Phillips, Kirch, Urban, Jones, Foust, Shelly and

XUM

Jesse. We enjoyed an interesting picture by Lederle.

Drs. J. P. Urban and C. P. E. Burgwyn were elected to membership. Dr. J. M. Suter of Abingdon and Dr. W. R. Jesse of Lebanon were guests.

T. J. TUDOR, *Secretary-Treasurer*

The Midtidewater Medical Society

Met at Gloucester C. H. on April 28th, for its regular quarterly meeting.

A program consisting of papers relating to Pediatrics was presented by Dr. Paul Hogg whose subject was "Immunizations in Children". Dr. Ward Anderson spoke on "Common Dermatologic Lesions in Children", and Dr. C. W. Beaven "Use of Antibiotics in Children Diseases." All are of Newport News.

Dr. Wm. H. Hosfield, West Point, presided.

The next meeting of the society will be held at Urbanna on the fourth Tuesday in July.

M. H. HARRIS, *Secretary*

Richmond Academy of Medicine.

At the meeting of the Academy on May 12, Dr. C. L. Outland presiding, Dr. Alexander Steigman of the University of Louisville, Louisville, Kentucky, spoke on "Poliomyelitis—Current Status of Active and Passive Prophylaxis".

Lynchburg Academy of Medicine.

The regular monthly meeting of the Academy was held on Monday evening, April 13th at Lynchburg General Hospital. The speaker of the evening was Dr. George Minor, Associate Professor of Thoracic Surgery at the University of Virginia, who spoke on "Cardiac Surgery".

No business of importance was discussed at this meeting.

The Princess Anne County Medical Society,

At a recent meeting re-elected Dr. Ira L. Hancock of Creeds as president, and elected Dr. James W. Todd of Virginia Beach as secretary. This Society meets monthly from September through May.

NEWS

Virginia General Practice Group.

Under the capable leadership of Dr. W. Linwood Ball of Richmond as General Chairman, Friday evening, May 8, marked the conclusion of the third successful Scientific Assembly of the VIRGINIA ACADEMY OF GENERAL PRACTICE, held at the Hotel Jefferson in Richmond. A total of 226 physicians registered for the three-day Assembly, coming from West Virginia, North and South Carolina and Michigan, as well as from Virginia.

Diabetes and Chest Physicians held their annual scientific sessions in the forenoon and afternoon of May 6, speakers presenting splendid papers and panel discussions. A record attendance at each session has encouraged the officers of the *Virginia Diabetes Association* and the *Virginia Chapter, American College of Chest Physicians* to consider a continuance of the arrangements with the Virginia Academy which has proved so successful this year.

There were forty-eight Technical exhibits and the Scientific exhibits were also excellent.

On Thursday evening, there was a cocktail party, banquet and entertainment with an address by Dr. John S. DeTar of Milan, Michigan, of the American Academy of General Practice.

An interesting program was enjoyed by the members of the Woman's Auxiliary for two days.

Dr. Richard M. Reynolds of Norfolk was the unanimous choice for the 1954-55 President of the Academy, with Dr. John W. Davis, Jr. of Lynchburg as Vice-President-Elect. Dr. W. Linwood Ball of Richmond was elected to succeed himself as Secretary, with Dr. Carl W. Meador of Richmond as Treasurer. Elected to fill the three places on the Board of Directors which will become vacant in October were—Drs. William A. Young of Richmond, Frank A. Farmer of Roanoke and Charles F. Manges of Blacksburg. Drs. Ira L. Hancock of Creeds and B. A. Hopkins of Stuart were elected to succeed themselves as Delegate and Alternate, respectively, to the Congress of Delegates of the American Academy of General Practice for a term of two years.

The 1954 Annual Scientific Assembly will be held in Richmond during the first week in May and the Hotel Jefferson was again selected as the meeting place.

H.M.S.

Scientific Exhibits for Roanoke Meeting.

The Scientific Exhibit Committee of The Medical Society of Virginia is now receiving applications for space at the annual meeting in Roanoke, October

XUM

18-21. The scientific exhibits have, in the past, formed a most significant part of the Society's scientific sessions, and the committee is particularly interested in exhibits of a scientific or teaching nature that would appeal to the general practitioner. All members having material of interest should apply for space and it is hoped they may ask for a minimum space that could serve their purpose.

Applications should be made on forms furnished by the Society. Write Dr. Allen Barker, 603 Medical Arts Building, Roanoke, Virginia, for these and return them to him when completed. Applications must be in by July 1st.

Action of Virginia State Board of Medical Examiners Upheld By Court.

As a warning to others who might apply for license in Virginia to practice medicine when they do not comply with the requirements exacted by the State Board of Medical Examiners, it is interesting to note that the circuit court of Fairfax County recently upheld the action of the Board in refusing reciprocity or endorsement to a graduate of Middlesex University School of Medicine, a school not properly registered with the State Board of Education of Virginia as maintaining a standard satisfactory to that Board.

Joint Meeting.

The Virginia Society and the West Virginia Academy of Ophthalmology and Otolaryngology held a joint meeting at the Homestead, Hot Spring, Va., May 3, 4, and 5. The two organizations furnished an excellent program and the social features were most enjoyable. Separate business sessions were held by the two on Sunday evening and other business meetings at a time not to conflict with the professional program. Dr. A. D. Morgan of Norfolk and Dr. Melvin K. McGehee of Huntington, W. Va., divided the honors in presiding.

At the last business session, Dr. Peter N. Pastore of Richmond succeeded to the presidency of the Virginia Society. Dr. G. Slaughter Fitz-Hugh (former secretary), Charlottesville, was named president-elect; Dr. H. L. Mitchell, Lexington, vice-president; and Dr. L. Benjamin Sheppard, Richmond, was selected as secretary-treasurer.

The Neuropsychiatric Society of Virginia

Held its Spring meeting at Westbrook Sanatorium, Richmond, on April 1. The program included the presentation of five papers as follows:

"Suicide—Evaluation of the Threat"—Dr. Richard W. Garnett, Jr., Charlottesville

"Homicide—Evaluation of the Threat"—Dr. Joseph R. Blalock, Marion

"Shock Therapy—An Out-Patient Discussion"—Dr. J. J. Hladys, Richmond

"Drug Therapy—The Choice in Disturbed Psychiatric Patients"—Dr. Thomas F. Coates, Richmond

"Emergency Commitment—The Application and Choice of Patients"—Dr. Joseph E. Barrett, Richmond

At this time the new officers for 1953-54 were elected and are as follows: Dr. Frank Strickler, President; Dr. Granville L. Jones, Vice-President; and Dr. R. W. Garnett, Jr., Secretary-Treasurer. Drs. Frank Curran and J. R. Saunders are members of the Executive Committee.

GRANVILLE L. JONES,
Retiring Secretary-Treasurer.

Dr. R. C. Longan,

Richmond, was elected president of the Memorial Guidance Clinic, Richmond, at the annual meeting of the board of directors at its meeting the middle of April. Dr. Rex Blankinship and Dr. W. T. Thompson were re-elected to the board of directors for a term of three years.

The Gill Memorial Eye, Ear and Throat Hospital,

Roanoke, has just completed the Twenty-Sixth Annual Refresher Course in Ophthalmology and Otolaryngology. There were about three hundred doctors in attendance. Forty-five states were represented including Canada and several foreign countries.

The Twenty-Seventh Annual Spring Congress will be held from April 5 to April 10, 1954.

Correction.

Kaufman, William H.: Vioform—Its Use In Dermatological Therapy, Virginia Medical Monthly 80:222 (April) 1953. The second paragraph should read: Although the preparation has been used for years by European dermatologists, and although introduced into dermatologic therapy in this country by Sulzberger as far back as 1929, only a scant literature has accumulated with reference to the use of Vioform in the treatment of diseases of the skin.

Dr. C. Bruce Morton,

Professor of Surgery at the University of Virginia Medical School, Charlottesville, addressed an open staff meeting of the Shenandoah Hospital, Roanoke, April 16. His subject was "Postcholecystectomy Symptoms Due to Cystic Duct Remenants" and his address was illustrated with lantern slides.

XUM

Your Advertisers.

Have you taken time to look over the advertisements in the Monthly? If not, you may be losing something valuable as they tell of many new preparations, and remind you of hospitals, instruments, x-ray and other equipment, infant foods, and many things which may have slipped the memory of a busy doctor. Take time to look over the advertising pages now, won't you? You may find it as fascinating as opening a prize bag.

Dr. E. W. Perkins

Of Richmond, participated in the symposium on the complications of eye surgery at the New York Academy of Medicine in New York City on April 22, and presented a paper on "The Complications of Eye Motility Surgery".

Dr. Lawrence Waring.

In its January 1953 issue of the MONTHLY, there was published a short account of the career of Lawrence Waring, M.D., who lived and practiced in Richmond around Civil War days and was known as "The Physician to the Poor." Under date of April 4, 1953, Dr. William H. Parker of Richmond, wrote the author, Dr. J. B. H. Waring, that he had read this account and stated further:

"I have an oil painting of Dr. Waring which has been in my home since early childhood. I believe he was in attendance at the birth of my sister in 1868. I will be very glad to send this portrait to you if you would like to have it."

Dr. J. B. H. Waring writes the MONTHLY that he acknowledged this letter and wrote the Doctor that he would be happy to receive the portrait of "this member of our clan of a bygone day whose career was a credit to 'God's Country' and to its Medical Profession. I would like the Physicians of Virginia to know of this handsome gift by Dr. Parker; and for Dr. Parker to know that this portrait of Lawrence Waring, M.D. will always have a place of honor in my care."

Highland Springs Doctor Honored.

Dr. B. Herman Bailey who, for twenty-six years has served the people in sections of Henrico, New Kent and Hanover Counties, has found it necessary to cut down on his work and is leaving Highland Springs for a home at Yorktown where he will engage in limited work. In appreciation of his service, the people of that community gathered on May 13th, to honor him and his wife with music, dancing and refreshments, and also presented the Doctor with a special gun cabinet built into his home at Yorktown.

Winchester Dedicates New Hospital.

On May 12, a new Memorial Hospital was dedicated at Winchester, the principal speaker at the ceremonies being Dr. Richard J. Ackart, executive director of the Virginia Hospital Service, at Richmond. The hospital first opened March 17, 1903, with 36 beds but with additions from time to time, has now been enlarged to 300 beds. It is said to be the second largest community-owned hospital in Virginia.

Dr. Ebbe C. Hoff,

Who has been engaged in research work at the Medical College of Virginia, Richmond, plans to go to England this month to receive the honorary degree of doctor of medicine from Oxford, which is being conferred on the basis of outstanding medical research projects. He received his medical degree from the Royal College of Physicians and Surgeons of London.

Dr. H. Holt Bradshaw,

Winston-Salem, N. C., professor of surgery at the Bowman Gray School of Medicine, delivered the annual J. Shelton Horsley Memorial lecture before a meeting of the Richmond Academy of Medicine on April 28. He spoke on "Ulceration of the Stomach and Duodenum". The lectureship was established by Dr. Guy W. Horsley in 1947 in honor of his father.

Virginia Obstetrical and Gynecological Society.

The Virginia Travel Club of this Society had an outstanding clinical program April 5 to 7 on their visits to Duke University, Durham, and the University of North Carolina at Chapel Hill. Operative clinics and clinicopathological conferences had been arranged and enjoyable entertainments were provided in both places. The Travel Club this year was composed of twenty-nine members and six guests.

Dr. John R. Kight of Norfolk is this year's president of the Society and Dr. Chester D. Bradley of Newport News secretary.

Dr. William A. Brumfield, Jr.,

First deputy state commissioner of health of New York, has been appointed professor and chairman of the department of Public Health and Preventive Medicine at State University College of Medicine at

XUM

Syracuse, N. Y. and is expected to assume his new duties in Syracuse about September 1st.

A native of Virginia, Dr. Brumfield was graduated from the University of Virginia in 1930, and later received the degree of Master of Public Health from the Johns Hopkins University School of Hygiene and Public Health. After public health service in several capacities, he entered the Army Medical Corps from which he was released with the rank of colonel in March 1946, when he returned to the State Department of Health of New York.

Dr. Joseph E. Barrett,

Williamsburg and Richmond, Commissioner of Mental Hygiene and Hospitals for Virginia, has been chosen winner of the good government award of the Junior Chamber of Commerce because of the forward strides made in recent years by the State hospital system. This award is made annually to a Williamsburg citizen for outstanding contribution in the field of government.

The Duke Medical Post-Graduate Course

Will be held at Duke University, Durham, N. C., June 22-25 inclusive. Registration fee is $25.00. Rooms are available in the University Graduate Dormitories and meals may be obtained on the grounds. Write Director of Post-Graduate Education, Box 3088, Duke Hospital, Durham, N. C.

The first two days will be devoted to discussions of Anesthesia. There will be lectures, demonstrations and round table discussions. The other two days will include general medical subjects, ward rounds or visits to the clinics. In addition to members of the faculty of the School of Medicine, the guest speakers are Dr. Howard M. Ausherman of the Veterans Hospital, Durham, and Dr. David A. Davis, of the University of North Carolina, Chapel Hill.

Dr. Weir Mitchell Tucker

Was elected early in May as president of the Richmond Chapter of the Mental Hygiene Society of Virginia and will take office in July.

Doctor's Office

For rent in a professional building, 1400 Colonial Avenue, Norfolk, Virginia. 2nd Floor, 4 large rooms, heat and all utilities furnished. $160 per month, immediate possession. H. W. Holland and Company, 506 Western Union Building, Norfolk, Virginia. Dial 27496 or 27704. (*Adv.*)

Wanted

Physician for the staff of the DeJarnette State Sanatorium, Staunton, Virginia. This is a psychiatric hospital of approximately 180-bed capacity. Starting salary $8,400.00 to $8,784.00 depending upon qualifications. Apply to the superintendent. (*Adv.*)

OBITUARIES

Dr. Lawrence Thomas Royster.

WHEREAS, Lawrence Thomas Royster, pioneer pediatrician, educator and writer, died at his residence in Charlottesville, Virginia, January 7, 1953, BE IT RESOLVED:

THAT the Albemarle County Medical Society has lost a beloved and highly esteemed member; that the medical profession an able teacher and clinician; the State of Virginia a wise counselor and faithful servant; the cause of children in general a devoted benefactor; and

THAT a copy of these resolutions be spread in the minutes of this Society, and a copy be sent to the Secretary of The Medical Society of Virginia.

Dr. Royster was born in Norfolk, Virginia, August 18, 1874. He received his early education at Norfolk Academy and later attended the University of Virginia where he received the degree of doctor of medicine in 1897. He received formal post-graduate training in New York, Boston, and Baltimore.

His early medical experience was in general practice in Norfolk, Virginia. He early became interested in child welfare work and founded the first Society for the Prevention of Cruelty to Children in that area.

In 1923 he was called to the University of Virginia as Professor of Pediatrics and assigned the task of establishing a Department of Pediatrics.

Dr. Royster was honored by membership in many distinguished societies and fraternities, and was a charter member of the Virginia State Pediatric Society and for over twenty-five years was a member of the State Board of Health, where he served well and faithfully.

Because of failing health in 1942 he retired as Professor of Pediatrics and Chairman of the Department of Pediatrics of the University of Virginia School of Medicine. His interest in children and in his many friends in the pediatric world never ceased until his death.

Respectfully submitted,
W. W. WADDELL, JR.
MCLEMORE BIRDSONG

Dr. Otis Lee Watkins,

Rustburg, died April 28, in a Lynchburg hospital. He was sixty-eight years of age and a graduate of the Medical College of Virginia in 1907. With the exception of a short time, he had practiced in Campbell County since. He was for several years county coroner and served in the Army Medical Corps in World War I and was a draft examiner during World War II. His wife and three children survive him.

XUM